Optical Able to Bring Child to Appointment Consent

Name: (Last)_____ (First)_____ (MI) ____ Date of Birth:_____

Printed Name of Parent or Legal Guardian (If applicable): _____

I give consent for the following individuals to bring my child for his/her optometry visits:

Name	Relationship to patient	Telephone Number

I understand during the course of a visit, any and all personal health information within the medical record of the child may be discussed with the representative. If there is any information that may be in my child's chart that I do not want them to know, I should not sign the consent. If my child has an eye/medical condition by history or exam that warrants a follow up appointment, it will be made for my child. The provider may request a parent/guardian be present at the follow up visit. If the medical condition warrants, the provider may choose to not complete a physical form until the eye/medical issues are addressed at a follow-up visit with the child and the parent/guardian present. The provider may decide to not perform tests or procedures at the provider's discretion. For example, if the provider does not feel the representative is able to give enough of a medical history to provide the best care for my child. I further understand that confidentiality between the minor and CSCHC and MFHC professionals will be ensured in specific areas designated by law and will not be discussed with the parent/guardian unless the minor agrees or is determined to be a threat to themselves or another person.

In signing this, I give my consent for the representative(s) listed above to sign for any necessary procedures necessary for the eye/medical care of my child and upon recommendation of the medical provider. To the release of relevant health information to the Center Street Community Health Center and Morrow Family Health Center in order to facilitate evaluation of my child's health needs. I further authorize the CSCHC and MFHC to release information regarding my child's treatment to the third party payor or others for purposes of billing, program management and evaluation in accordance with federal and state laws and regulations regarding confidentiality, and my insurance carrier or medical assistance to be billed for services received.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

If you do not agree with these terms, we will be unable to serve as your provider.