Ophthalmology Consultants
of Fort Wayne, P.C.

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HEALTH CARE CONSENT FOR TREATMENT OF A MINOR

I am the parent / guardian / or other legally authorized representative of _____, a minor (hereafter "Patient") and I have authority to execute this Consent. I hereby consent to the administration of health care (including care, treatment, service or procedure to maintain, diagnose or treatment of Patient's condition) by Ophthalmology Consultants of Fort Wayne, P.C., for Patient. The conditions or limitations, if any, on my consent and the authority delegated to Ophthalmology Consultants of Fort Wayne, P.C. include:

Name _____ Relationship _____

Name _____ Relationship _____

By my signature below, I acknowledge that I am giving my consent to the administration of health care by Ophthalmology Consultants of Fort Wayne, P.C. for Patient voluntarily, and I hereby knowingly and voluntarily enter into this Consent. I have been informed and acknowledge that I may withdraw my consent hereunder at any time upon written notice to Ophthalmology Consultants of Fort Wayne, P.C.

The contents of this "Health Care Consent for Treatment of a Minor" have been discussed with the Patient and Patient's parent / guardian / representative.

Parent / Guardian / Representative's Signature: _____

Date: _____ Printed Name: _____

Witness Signature: _____

Date: _____ Printed Name: _____