Pediatric Ophthalmology Associates of Hawaii, Inc.

Dr. David A. Young

Consent for Treatment of Minor

This will authorize Dr. David A. Young and other physicians under his supervision to provide medical care including examination, treatment, imaging, photography, laboratory tests, local anesthetics, medical diagnosis and hospital care to ____ __________________, a minor.

(NAME OF PATIENT) **(DATE OF BIRTH)**

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospitalization in order to avoid delay in providing such treatment as is deemed necessary by Dr. David Young.

This authorization to treat will remain in effect until patient is 18 years of age unless revoked sooner in writing.

________________ ____

DATE SIGNATURE OF PARENT/LEGAL GUARDIAN/LEGAL CUSTODY

____

SIGNATURE OF PARENT/LEGAL GUARDIAN/LEGAL CUSTODY

____

RELATIONSHIP (IF SIGNED BY OTHER THAN PARENTS/LEGAL GUARDIAN)

__________ INITIALS

This form authorizes said minor to present for minor care and treatment **unaccompanied by adult**. (this applies to children 13 years and older)

__________ INITIALS

This form authorizes said minor to present for minor care and treatment **accompanied by an adult other than his/her parent or legal guardian.**