Patient ID: _____

Consent & Request for Treatment of a Minor Child

As a parent or legal guardian, I hereby request treatment by Vine Vision doctors and/or staff of my minor child:

Childs Name: _____

Childs Date of Birth: _____

I understand that evaluation and treatment of my minor child may involve MEDICAL and FINANCIAL decision making. I authorize the adult individual{s) below to make decisions on my behalf:

Name of adult to act on my behalf: _____

I understand that this consent form will expire 3 years after today's date. I also understand that I may discuss my child's care with his or her provider or Vine Vision staff at any time.

I have read and understand the above information.

Printed Name: _____ Relationship: _____

Signed: _____ Date: _____