PALMETTO RETINA CENTER

CONSENT FOR TREATMENT

The following information is to be completed by the patient or the patient's legal authorized representative/parent:

I understand the type and extent of services will be determined following an initial evaluation and thorough discussion with me. The goal of the evaluation process is to determine the best course of treatment for me/the patient.

I hereby consent to medical treatment for myself or for the patient for whom I am the parent or legally authorized representative.

PATIENT NAME:	**DATE:**

SIGNATURE:

If signature is not that of the patient, indicate below the relationship of the person signing for the patient:

☐ **PARENT** ☐ **LEGAL GUARDIAN** ☐ **SPOUSE** ☐ **CAREGIVER** ☐ **OTHER**

_____

If patient or patient's representative does not sign, indicate the reason why signature could not be obtained:

_____

_____

PRC STAFF MEMBER SIGNATURE:	**DATE:**

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the release of any information, including the diagnosis and records of any treatment or examination rendered to me during the period of such care, to third party payors and/or other healthcare providers and ancillary testing services.

PATIENT NAME:	**DATE:**

SIGNATURE:

If signature is not that of the patient, indicate below the relationship of the person signing for the patient:

☐ **PARENT** ☐ **LEGAL GUARDIAN** ☐ **SPOUSE** ☐ **CAREGIVER** ☐ **OTHER**

_____

If patient or patient's representative does not sign, indicate the reason why signature could not be obtained:

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_____

PRC STAFF MEMBER SIGNATURE:	**DATE:**