AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

Medical Treatment of a Minor (Age 18 and under)

by

HEARTLAND EYE CONSULTANTS and/or Developmental Vision Associates

Name: _____ for (Minor Child's name) _____ DOB: _____

□ Mother □ Father □ Legal Guardian □ Son □ Daughter

I do hereby state that I have legal custody of the aforementioned minor child. I grant my authorization and consent for _____ (hereafter "Designated Adult") to bring my child in for Therapeutic Treatment, Progress Exams, and Re-Evaluations.

I agree to assume financial responsibility for all expenses of such care. It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Designated Adult in the exercise of his or her best judgment upon the advice of any such medical personnel.

This authorization is effective through: _____. Signed this ____day of_____, 20__.

Parent / Legal Guardian Signature: _____ Printed Name: _____

Witness Signature: _____ Printed Name: _____