Consent for Medical Treatment

Patient Name:_____Date of Birth: _____

I hereby give my consent for _____
Name of person-relationship / agency
to bring my child for diagnosis and treatment and recommended vaccinations. Information that can be released to the person accompanying my child includes:

_____Lab Results

_____Appointments

_____Treatment Information

_____Results of the Examination

Unless indicated here, the information will NOT INCLUDE; 1) Past medical history other than what is relevant to the current visit; 2) Mental health information and/or communicable disease information, including human immunodeficiency virus (HIV), AID-related complex (ARC) and acquired immunodeficiency syndrome. (AIDS, if contained in said medical record)

☐ I authorized mental health, communicable disease information, including HIV, ARC, and AIDS to be shared also.

This authorization will expire on _____ or until withdrawn by me.

I understand that this authorization is subject to revocation at any time, except to the extent that action has been taken in reliance on this authorization. In order to revoke this authorization, I must deliver a revocation in writing, and that after such revocation is delivered, no further information will be furnished pursuant to this authorization.

When information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I acknowledge that I am responsible for all charges in connection with the care and treatment of my child during the period of the authorization.

Signature of patient/legal Guardian :_____Date:_____

Print name of patient/legal Guardian:_____

Address: _____

Home Phone:_____Cell Phone: _____Work Phone: _____

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