Consent Form

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). To help us protect your child's PHI please complete the form below.

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Emergency Contact

In the event of an emergency, I give Children's Medicine permission to contact the persons listed below.

Name _____ Relationship to patient _____Phone Number: _____

Name _____ Relationship to patient _____Phone Number: _____

Name _____ Relationship to patient _____Phone Number: _____

Name _____ Relationship to patient _____Phone Number: _____

Parental Consent

O There is no one other than the mother or father who will bring my child to Children's Medicine, P.C. for medical treatment.

-OR-

O I give permission for the persons listed below to bring my child to Children's Medicine, P.C. for medical treatment.

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

Contact Consent

O There is no one other than the mother or father who can be contacted regarding my child's lab results, billing information, and other PHI.

-OR-

O I give permission for the persons listed below to be contacted regarding my child's lab results and other PHI.

 Check here if same as "Parental Consent" section above _____.
Patient/Parent/Guardian Signature

Name _____ Relationship to patient _____Phone Number: _____

Name _____ Relationship to patient _____Phone Number: _____

Name _____ Relationship to patient _____Phone Number: _____

Name _____ Relationship to patient _____Phone Number: _____

Children's Medicine, P.C. can leave normal results on the following phone number: _____

belonging to _____.
Full Name

Request Consent

O There is no one other than the mother or father who can request and/or pick up my child's forms, prescriptions, and other PHI.

-OR-

O I give permission for the persons listed below to request and/or pick up my child's forms, prescriptions, and other PHI.

 Check here if same as "Parental Consent section above _____.
Patient/Parent/Guardian Signature

 Check here if same as "Contact Consent" section above_____.
Patient/Parent/Guardian Signature

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

_____ _____
Signature of Patient/Parent/Guardian Date

_____ _____
Printed name of Patient/Parent/Guardian Printed name of other Parent/Guardian