



## 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

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-

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**

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-

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**

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-

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