Consent Form (to be used for patients 18 and older)

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 PHI please complete the form below.

Patient Name _____ Date of Birth _____

Patient Phone Number _____

☐ Children's Medicine, P.C. can leave normal results on the above phone number belonging to me _____.

Initial

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 _____

Request Consent

☐ There is **no one** who can request medical information, pick up my forms, prescriptions, or access any other PHI. Please check the box an initial here _____.

OR

☐ I **give permission** for the persons listed below to request medical information, pick up my forms, prescriptions, and discuss other PHI.

Name _____Relationship to patient _____Phone Number _____

Name _____Relationship to patient _____Phone Number _____

Name _____Relationship to patient _____Phone Number _____

Name _____Relationship to patient _____Phone Number _____

_____ _____

Signature of Patient Date