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. The patient or their representative may revoke or change this consent form at any time by completing a new Children's Medicine, P. C. consent form and submitting to the appropriate office personnel. **This consent form will remain in effect until revoked in writing or replaced with new consent form.**

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 __________________

3685 Lawrenceville Highway | Suite 100
Lawrenceville, GA 30044
(770) 921-7386 | fax (770) 923-8529

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

Date/Initials: ________________ Date/Initials: ________________

Date/Initials: ________________ Date/Initials: ________________

***Form must be signed.**