Coastal Pediatrics

HIPAA & CONSENT

Patient Name:	Date of Birth:
Patient Name:	Date of Birth:
Patient Name:	Date of Birth:
Patient Name:	Date of Birth:
Patient Name:	Date of Birth:

Authorized person(s) to bring patient & consent for treatment on your behalf
*****excluding Parent or Legal Guardian(s)•••**

Relative/Friend Name: **Relationship:** **Phone:**

Consent for Treatment

I authorize the above-named individual(s) to consent to treatment for my children. This may include but is not limited to, consent for necessary medications, vaccinations, procedures, and hospitalizations. This practice may relay any medical information about my child necessary for the above-named individual(s) to provide informed consent to the treatment. I understand that the provider will communicate his or her findings and treatment plan to the caregiver who brings in the child, and that under most circumstances, a follow up call to me personally should not be necessary.

Coastal Pediatrics Is authorized to release Protected Health Information about the above-named patients in the following manner:

PLEASE CHECK YOUR PREFERRED MEANS OF COMMUNICATION

☐You may call my home and leave a detailed message regarding appointments, lab & x-ray results, or other health care information with someone or on an answering machine if I am not available.

☐You may call my cell phone and leave a detailed message regarding appointments, lab & x-ray results, or other health care information on my answering machine if I am not available.

Patient Rights

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing, and you must specify how or where you wish to be contacted. A request form may be obtained at the front desk. You have the right to inspect and copy medical information that may be used to make decisions about your care. A request form may be obtained at the front desk. We may deny your request to inspect and copy in certain very limited circumstances. I have reviewed this office's Notice of Privacy Practices which explains how my or my child(ren)'s medical information will be used and disclosed, and/or I understand that I am entitled to receive a copy of this document upon my request. Other uses and disclosures of medical information not covered by our Notice of Privacy Practices or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission in writing, at any time.

I, the undersigned, consent to the care and treatment by the attending physician, his or her associates, or assistants. I attest that I am the parent or legal guardian and I have the legal authority to make this agreement. I understand that I can revoke this authorization for any or all of these individuals at any time.

Parent or Legal Guardian (Print)

Signature - Parent or Legal Guardian

Date

•••For Office Use Only•••

Coastal Pediatrics attempted to obtain written acknowledgement of receipt of Office Policies, HIPAA & Consent, but acknowledgment could not be obtained for the following reason·

D Individual refused to sign
☐ An emergency situation prevented us from obtaining the acknowledgement
☐Other (Please Specify):