Consent to Treat

Written Acknowledgement of Receipt of ALICE PEDIATRIC CLINIC

Notice of Privacy Practices

_____ (Please initial)

I acknowledge receiving ALICE PEDIATRIC CLINIC (APC) Notice of Privacy Practices (The Notice). The Notice explains how APC may use and disclose your protected health information for treatment, payment and healthcare operations purpose. “Protected health information” means your personal health information found in your medical and billing records.

If you have questions about the Notice, Please contact the APC Privacy Office. You may find their contact information located in the Notice.

General Consent to Treat

_____ (Please initial)

I am the parent/guardian of _____ (name of patient). I have the legal right to consent to medical and surgical treatment for this patient.

I voluntarily authorize and consent to the medical care, treatment and diagnostic tests that Alice Pediatric Clinc and their designated associates or assistants believe are necessary for this child. I understand that by signing this form, I am giving permission to the doctors, nurses, physician assistants and other healthcare providers in this medical office to provide treatment to this child as long as this child is a patient in this office, or until I withdraw my consent.

Consent to Release and Obtain Information

_____ (Please initial)

In agreement with federal and state law, I agree to allow ALICE PEDIATRIC CLINIC to deliver the necessary care to this child in order to provide continuity of care and treatment. ALICE PEDIATRIC CLINIC and/or the patient’s provider may obtain from any source and examine and use, or discuss and disclose, the patient’s medical record and information to treating hospital personnel and agents, other healthcare providers, medical records auditors, professional committees, care evaluators and governmental agencies. This information can include, but is not limited to: medical history, examinations, diagnoses, treatments any psychiatric, drug and alcohol abuse or genetic testing information, or HIV or AIDS information. This consent to release and obtain information is valid until revoked. The undersigned may revoke the consent in writing at any time, except with regard to disclosures that have already been made in reliance on such consent.

_____ (Please initial)

I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

Electronic Prescriptions (E-Prescribing)

_____ (Please initial)

I voluntarily authorize ALICE PEDIATRIC CLINIC to allow E-Prescribing for the patient’s mail order prescription, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medical dispense history as long as this child is a patient at this office, or until I withdraw my consent.

Patient (s) Name: _____

Signature of Parent / Guardian: _____

Date: _____