**Poole and Thomas Pediatrics PLC**
**Consent to Treat/Medical Records/Privacy**

I, _____, the parent/legal guardian of the below named child(ren),

| Child's (1st and Last) Name | Date of Birth | Child's (1st and Last) Name | Date of Birth |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

(Until we are notified in writing, Poole & Thomas Pediatrics will assume that a child's biological &/or legal parents are both legal guardians who have access to treatment options and medical information for that child.)

I hereby authorize and consent to the examination/treatment of my child(ren) during the office and facility visits by the physician and clinical staff of Poole & Thomas Pediatrics. In addition, I give permission for the following person(s) to bring my child to Poole & Thomas Pediatrics in my absence and to act on my behalf in authorizing medical care and treatment.

In the event of an emergency or other Illness, I understand that the physicians and staff of Mack & Poole Pediatrics will deliver medical care deemed necessary regardless of the accompanying adult.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

*Anyone not mentioned above who brings your child into the office for treatment must have a signed authorization from the child(ren)'s legal guardian.

**Medical Records/Privacy**

At Poole & Thomas Pediatrics, we are committed to protecting the security and privacy of your child's personal information. Medical records are the property of Poole & Thomas Pediatrics. These records are kept in a secure location, and are accessed only for the purposes outlined by the Notice of Privacy Practices (revised 9/23/13). Our revised Privacy Notice Is available at www.ptpediatrics.com the bottom of each page entitled Patient Privacy, you may also ask for a copy in our office. Records may be released or shared with other health care professionals for the treatment of your child. Patients are entitled to one free copy of their medical records only after an authorization for release is signed. Additional copies may be made for a fee of $1.OO per page, per KY House Bill 250.

- By signing below I acknowledge that I have received Poole & Thomas Pediatrics Notice of Privacy Practices and consent to treat information. I understand that I can edit any of the terms below. I understand that PTP may call my home & place of employment for healthcare reasons, appointments reminders, to resolve billing issues, and may mail me informational postcards to my home address. PTP may also mail bills to your mailing address.
- I understand that PTP may leave messages on my answering machine regarding appointments and limited lab Information.
- I understand that PTP may use an email address or fax, provided by me to communicate appointment, billing issues, immunization certificates and other forms requested by the parent.
- I authorize PTP to email or fax immunization certificates and/or school forms to my personal or work fax, or mail to my home address provided.
- I authorize PTP to discuss patient information with adults or other minors present during the visit regardless whether I am present.
- I understand that if I send a picture of myself or child(ren) PTP may display it within the office.

Parent Signature_____ Date_____