# GULF SHORES PEDIATRICS P.C.

## CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I authorize the examination and treatment of Patient Name(s):1) _____

2) _____ 3) _____ 4)_____ 5)_____

by members of Gulf Shores Pediatrics. I understand the examination and follow up may include the use of medications, lab tests and other non-invasive diagnostic procedures.

I understand that should more specialized tests and procedures be required, these will be explained by the Physician or his/her designee and my consent will be obtained.

**In the event that I am unable to attend subsequent visits with my child, I authorize Gulf Shores Pediatrics to treat my child if he/she is brought to the clinic by:**

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

***I understand that such treatment does not include any invasive procedures.***

I hereby authorize Gulf Shores Pediatrics, P.C. to release any medical information or medical records regarding my child's medical treatment or condition, including drug/alcohol use/abuse, psychiatric evaluations/treatment, and/or AIDS testing for AIDS (HIV) to appropriate consulting medical personnel without necessity of obtaining further permission from me, except as required by law. When required by law, a separate authorization/consent will be provided to me with regard to releasing data or information of this nature. If I do not authorize the release of this information, I understand the continuity of care could be affected. I agree to assume all responsibility of my refusal to exchange this information and also not to hold my physician(s), of Gulf Shores Pediatrics, P.C. responsible for any adverse results from my refusal to release this information.

I authorize the release of information for processing Health Insurance Claims. If I do not consent to the release of information, I understand that I am personally responsible or cause the Responsible party to be liable for all or any part of my bills for treatment and/or Consultation by Gulf Shores Pediatrics, P.C.

Gulf Shores Pediatrics, P.C. recognizes that medical record information received/released by this clinic is protected by State and Federal confidentiality laws. Any further disclosure of this information is prohibited.

Parent/Patient: _____ Relationship to Patient: _____ Date: _____

Witness: _____ Medical Record #: _____ Date: _____