PEDIATRIC & ADOLESCENT ASSOCIATES, PSC
Consent to Treat/Medical Records/Privacy

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

Name of Child	Date of Birth	Sex
_____	_____	_____
_____	_____	_____
_____	_____	_____

Hereby authorize and consent to the examination and/or treatment of my child(ren) during office and facility visits by the physicians and clinical staff of Pediatric & Adolescent Associates. In addition, I give permission for the following person(s) to bring my child to PAA in my absence and to act in my behalf in authorizing medical care and treatment in my absence. In the event of emergency or other illness, I understand that the physicians and staff of PAA will deliver any medical care deemed necessary regardless of the accompanying adult. Unless we are notified in writing, PAA will assume that a child's biological and/or legal parents are both legal guardians who have access to treatment options and medical information for that child.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Medical Records/Privacy

At Pediatric & Adolescent Associates, we are committed to protecting the security and privacy of your child's personal information. Medical records are the property of PAA, kept in a secure location, and are accessed for only purposes outlined by the *Notice of Privacy Practices*. Records may be released or shared with other health care providers for treatment of your child. Patients are entitled to one free copy of their medical records only after an authorization for release is signed.

- I have received a copy, or been made aware I may have access to a copy, of the updated Notice of Privacy Practices from Pediatric & Adolescent Associates.
- I understand that PAA, its attorney and/or its agents including collection agencies may call my home, cell phone & place of employment for healthcare reasons, appointment reminders and to resolve billing issues.
- I understand that PAA, its attorney and/or its agents including collection agencies may contact me through email if I provide my email address at any time.
- I understand that PAA may use postcards to notify me of appointments or other pertinent information.
- I understand that PAA may fax immunization certificates, school excuses, physical/sports forms, and/or medication instructions to my personal or work fax, or my mail to my home. *PAA cannot fax or send these documents to third parties (schools, daycares, etc.) without a separate, signed authorization form.*
- I understand that PAA may leave messages on my answering machine regarding appointments and limited lab information.
- I understand that PAA may discuss patient information with adults or other minors present during the visit.
- ***I understand and agree to all of the above unless I strike through one of the statements.***

→ _____ _____

Signature of Parent/Guardian *Date*