Pediatric & Adolescent Associates, PSC

Consent to Treat/ Medical Records/ Privacy

18 years & older

I, _____, hereby authorize and consent to the examination and/or treatment during office and facility visits by the physicians and clinical staff of Pediatric & Adolescent Associates.

By signing below, I authorize Pediatric & Adolescent Associates to release my medical and billing information to:

Name:_____ Relationship:_____ Phone #:_____
Name:_____ Relationship:_____ Phone #:_____
Name:_____ Relationship:_____ Phone #:_____

If there is ever a change in this request, please notify the staff of Pediatric & Adolescent Associates.

By signing below, I authorize the following individuals to request prescription refills on my behalf, pick up prescriptions, x-rays, etc on my behalf:

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 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 your treatment. 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 of 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 may 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 Patient Date