PEDIATRIC STAFF PLLC

AUTHORIZATION AND AGREEMENTS FOR
MEDICAL EXAMINATION/TREATMENT/SERVICES
AND
THE USE AND DISCLOSURE OF HEALTH INFORMATION

Consent For Examination: I understand that medical treatment may be necessary for the patient by Pediatric Staff's physicians, associates or assistants. I understand the examination procedures will be explained to me and I shall consent to the partial or complete examination. I understand the examination results will be provided to me with recommendation. The responsibility for any follow-up examinations to check abnormalities found and treated, lies with me (parent/guardian) and not the physician, associates or assistants. I hereby release my examiner from all responsibility in connection with my child's examinations.

Consent For Treatment: I understand that medical treatment is necessary for the patients by our physicians, associates or assistants. I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the physician. No guarantee or assurance has been given by anyone as to the results that may be obtained by such treatments.

Consent To Examine/Treatment/Service In The Absent Of Parent/Guardian: I understand that there may times when I must authorize someone else to bring my child for medical exam/treatment or services therefore, it is my responsibility to inform the office in a timely manner. It is my responsibility to ensure that the authorized person also brings current insurance information or payment for services rendered (co-pays, deductibles etc.). In my absence I take full responsibility for I understand that the authorized person will communicate the information to me as a result of my child's exam/treatment or service. I understand and know that the responsibly lies with me (parent/guardian) and not the physician, associates or assistants. I hereby release my child's examiner from all responsibility in connection with my child's examine/treatment or service.

Consent To Use And Disclosure Healthcare Information: I understand that as part of my child's healthcare, Pediatric Staff originates and maintains health records describing health history, symptoms, examination, treatments, test results, diagnoses, out of office referrals, insurance information and plans for future care or treatment. ***I understanding that this information serves as:*** *A basis for planning and communicating with other healthcare professionals who contribute to the care and treatment of my child. A tool for routine healthcare operations such as assessing cares quality and reviewing the competence of healthcare professionals. A source of information for applying my Childs diagnosis, treatment and services to my bill. A means by which a third-party payer can verify that services billed were actually provided.*

I Understand That I Have The Right: *To object to the use of my childs health information for directory purposes. To request restrictions as to how my child's health information may be used or disclosed to carry out treatment, payment or healthcare operations, Pediatric Staff Physicians is not required to agree to the restrictions requested. To revoke this authorization/consent in writing, except to the extent that Pediatric Staff Physicians has already taken action in reliance thereon.* I have read and acknowledge the above information. ***If I have not been offered a copy of this form it will be my responsibility to ask for one.***

Patient	D.O.B.	Date
Signature	Relationship	Witness