Please List All Children's Names, Birth Dates, & Any Health Issues

Name:	*Date of Birth:*	*Health Issues:*

Patient Communication & Consent To Treat

It is the office policy of Professional Park Pediatrics not to release confidential medical information to family members or friends, except for (1) parent/legal guardian request in writing, (2) other authorized persons, (3) as we reasonably infer from the circumstances (ex. If you have a friend/family member accompanying, we assume that they are entitled to receive information regarding treatment, unless there is an objection from the parent/guardian/patient), (4) in the event of an emergency, or (5) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your child's medical information to be provided to family members, friends, or caretakers/baby sitters, please indicate that below so that we may best serve you.

If you do not want any of your medical information provided to a certain party, or to your family members, please check the "no" box below. By signing below, you authorize the following people to receive information regarding your child's treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Both parents will automatically have authorization unless court documents are presented specifically stating one is not authorized.

Circle Relationship	*Name*	*Authorized (Yes)*	*Not Authorized (No)*
Parent/Spouse/Other:		Yes	No
Parent/Spouse/Other:		Yes	No
Parent/Spouse/Other:		Yes	No
Parent/Spouse/Other:		Yes	No
Parent/Spouse/Other:		Yes	No

P**arent/Guardian Signature**:_____ **Date**:

Print Name:_____ **Relation to Patient (Circle)**: *Parent* *Guardian*