Snake River
PEDIATRICS
Infants, Children, & Adolescents

Blanket Consent Form for Health Care Services for Minor and Disclosures

Providing blanket consent is optional and may, instead, be given on a case-by-case basis

Minor Patient Name: ____DOB ________________________________

Authority

I am the parent, guardian or other person legally authorized by Idaho law to consent for health care services for the Minor Patient pursuant to Idaho Code § 32-1015

Consent for Treatment

I voluntarily consent to and authorize Snake River Pediatrics and its employed or affiliated physicians, practitioners, and staff (collectively Providers) to render the following health care services to the Minor Patient:

[ ] **General Consent:** Medical evaluation, diagnosis, and treatment; diagnostic services including lab tests or radiology procedures; prescription and administration of medications; therapy; counseling; and any other health care services as defined in I.C. § 32-1015 deemed reasonably necessary and appropriate by the treating Provider. This consent share constitute a “blanket consent” within the meaning of I.C. § 32-1015 (4)(a) and no further consent is required to authorize such health care services.

Or

[ ] Consent for Specific Care (Describe): ____

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Authorization to Release Non-Public Personal Information

I certify that I have received and read a copy of the Snake River Pediatrics, PC Patient Information Privacy Policy. I hereby authorize Snake River Pediatrics, PC providers to individually release any of my own or my Minor Patient’s medical or incidental nonpublic personal information that may be deemed necessary for medical evaluation, treatment, consultation or for the processing of insurance benefits.

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Authorization to Mail, Call or E-Mail

I certify that I understand the privacy risks of mail, phone calls, and e-mails. I hereby authorize a representative of Snake River Pediatrics, PC to mail, call, or e-mail me with communications regarding my healthcare or my Minor Patient's healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Snake River Pediatrics, PC to that effect in writing.

Lab, X-Ray or Diagnostic Services

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services that were not performed by the providers or staff at Snake River Pediatrics, PC. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

Acknowledgement of Notice of Privacy Practices

I have been given the opportunity to read and/or receive a copy of the Notice of Privacy Practices for the office of Snake River Pediatrics, PC, detailing how my information may be used and disclosed as permitted under federal and state law. I have read, understand, and agree to the foregoing, and I understand and acknowledge that Snake River Pediatrics and/or its Providers will render health care services in reliance on this consent.

Electronic Scribe Consent

I understand that my provider may use an electronic scribe during my visit. The use of the electronic scribe allows our providers to capture the visit without the need to type and allows them to give their undivided attention to the patient. I hereby authorize the use of an electronic scribe during my medical and behavioral health appointments at Snake River Pediatrics.

Signature ____ **Date:** ____________________________

Phone number ____

Relationship to minor patient: ____