FORT WAYNE PEDIATRICS

HIPAA - PATIENT MEDICAL CONSENT & AUTHORIZATION FORM

PATIENT NAME_____**DATE OF BIRTH**_____

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Due to HIPAA regulations, we are not permitted to give out medical information about your child to anyone except his or her parents or a legal guardian. No one except parents or legal guardians may authorize medical treatment for your child in our office. If you wish someone other than a parent or legal guardian to be allowed access to medical information, including test results, appointment times, immunizations, medical records, etc., please indicate below. If you wish someone other than the child's parent or legal guardian to bring the child to the visit and authorize any medical treatment needed in your absence (i.e. grandparent, aunt, etc.), please indicate below.

1._____Relationship_____

☐ Consent for information ☐ Consent for authorization for medical treatment

2. _____Relationship_____

☐ Consent for information ☐ Consent for authorization for medical treatment

3._____Relationship_____

☐ Consent for information ☐ Consent for authorization for medical treatment

4._____Relationship_____

☐ Consent for information ☐ Consent for authorization for medical treatment

If an individual not listed above brings my child into the office, a signed consent form must be presented at the time of the visit. I understand and have been provided access to the Notice of Privacy Practices.

_____ _____ _____

PARENT'S SIGNATURE PRINTED NAME DATE