With this consent, the Office of DV Pediatrics, LLC may:

- Call my home or other location that I specify, and leave a message regarding appointment reminders, insurance items, financial information, and any calls pertaining to my child's clinical care, including lab and x-ray results.
- Use and/or disclose certain protected health information (PHI) about my child for schools, camps or sports, on a form that I submit for completion.
- Provide immunization records or forms by fax to my child's school.

Please indicate how you prefer to be contacted regarding the following (**check *one* for each item**):

Medical Issues: o Home phone o Cell Phone Phone #___________________

Appointment Reminders: o Home phone o Cell Phone Phone #___________________

Appointment Recalls: o Home phone o Cell Phone Phone #___________________

Optional:
I give permission to the office of DV Pediatrics, LLC to treat and/or immunize my child in the event that I am unable to accompany him or her to the office. I understand that in all situations the doctor prefers to have a parent present to obtain a medical history and to give permission for treatment or vaccinations. By sending my child with a caregiver or by sending my adolescent child alone, I am giving advance consent to any medical procedure the physician deems necessary.

Persons other than a parent or legal guardian authorized to accompany my child to an appointment include:

Name ______________________________ Relationship: _______________ Phone #_____________

Name ______________________________ Relationship: _______________ Phone #_____________

Name ______________________________ Relationship: _______________ Phone #_____________

Child's Name(s): ____ DOB: _______________

Child's Name(s): ____ DOB: _______________

Child's Name(s): ____ DOB: _______________

Child's Name(s): ____ DOB: _______________

Signature of Parent/Guardian: ____

Print Parent/Guardian Name: ____ Date:_________________

Email Address: _______________________@____

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