CONSENT TO TREATMENT

Patient's Name _____

Your Name_____

Patient's Date of Birth _____

Relationship to patient _____

General Consent to Treat

I am the parent or guardian of the above-named minor. I have the legal right to consent to medical and surgical treatment for this patient. I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that Pediatric Offices at Willow Bend and its designated associates or assistants believe are necessary for this child. I understand that by signing this form, I am giving permission to the doctors, nurse practitioners, physician assistants and other healthcare providers in this medical office to provide treatment to this child as long as this child is a patient in this office, or until I withdraw my consent.

Consent to Release and Obtain Information

In agreement with federal and state law, I agree to allow Pediatric Offices at Willow Bend to deliver the necessary care to this child in order to provide continuity of care and treatment. Pediatric Offices at Willow Bend and/or the patient's provider may obtain from any source and examine use, or discuss and disclose, the patient's medical record and information to treating hospital personnel and agents, other healthcare providers, medical records auditors, professional committees, care evaluators and governmental agencies. This information can include, but is not limited to: medical history, examinations, diagnoses, treatments any psychiatric, drug and alcohol abuse or genetic testing information, or HIV or AIDS information. This consent to release and obtain information is valid until revoked. The undersigned may revoke the consent in writing at any time, except in regard to disclosures that have already been made in reliance on such consent.

Electronic Prescriptions (E-Prescribing)

I voluntarily authorize Pediatric Offices at Willow Bend to allow E-Prescribing for the patients mail order and traditional prescription, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medical dispense history as long as this child is a patient at this office, or until I withdraw my consent.

Final Acknowledgement

I have read this form, or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

X _____

Your Name Here