Poole&Thomas
personal pediatric care

CONSENT TO TREAT, MEDICAL RECORDS, and PRIVACY

I, _____ the parent or legal guardian of the below named child(ren),

Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____

Until we are notified in writing, Poole and Thomas Pediatrics will assume that a child's biological and/or legal parents are both legal guardians who have access to treatment options and medical information for that child.

I hereby authorize and consent to the examination/treatment of my child(ren) during the office and facility visits by the physician and clinical staff of Poole and Thomas Pediatrics. In addition, I give permission for the following person(s) to bring my child to Poole and Thomas Pediatrics in my absence and to act on my behalf in authorizing medical care and treatment.

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Anyone not mentioned above who brings your child into the office for treatment must have a signed authorization from the child(ren)'s legal guardian.

MEDICAL RECORDS and PRIVACY

At Poole and Thomas Pediatrics, we are committed to protecting the security and privacy of your child's personal information. Medical records are the property of Poole and Thomas Pediatrics. These records are kept in a secure location, and are accessed only for the purposes outlined by the Notice of Privacy Practices (Revised 9/23/13). Our revised Privacy Notice is available at www.ptpediatrics.com , or you may request a copy from our office. Records may be released or shared with other healthcare professionals for the treatment of your child. Patients are entitled to one free copy of their medical records only after an authorization for release is signed. Additional copies may be made for a fee of $1.00 per page, per KY House Bill 250.

- By signing below, I acknowledge that I have received Poole and Thomas Pediatrics Notice of Privacy Practices and consent to treat information. I understand that I can edit any of the terms below. I understand that PTP may call my home and place of employment for healthcare reasons, appointment reminders, to resolve billing issues, and may mail me information postcards to my home address. PTP may also mail bills to my mailing address.
- I understand that PTP may leave messages on my answering machine regarding appointments and limited lab information.
- I understand that PTP may use an email address or fax, provided by me to communicate appointment information, billing issues, immunization certificates, lab and test results, and other forms requested by the parent.
- I authorize PTP to email or fax immunization certificates and/or school forms, or to mail to my home address provided.
- I authorize PTP to discuss patient information with adults or other minors present during the visit regardless whether I am present.
- I understand that if I send a picture of myself or child(ren) PTP may display it within the office.

_____ _____
Parent Signature Date