

PEDIATRIC CARE SPECIALISTS
CONSENT FORM

Patient's Name _____

Date-of-Birth _____

I understand by checking any of the information below I waive my/and or my child's rights of confidentiality and I cannot hold Pediatric Care Specialists responsible for any information that may be overheard or repeated.

I authorize Pediatric Care Specialists to:

- Leave treatment/advice/instructions/results on my voicemail or answering machine.

Give treatment advice/instructions/results to: (mark EACH box that you are consenting to)

Babysitter

Grandparents

Aunt/Uncle

Siblings

Other _____

- Contact me/designee at work with treatment advice/instructions/results pertaining to my child.

- Release information to my child's school/daycare (forms, excuses, information) at my verbal request.

- To mail/fax information at my verbal request.

- I allow Children's Hospital to release information from their facility to our PCP, Pediatric Care Specialists at Pediatric Care Specialists' request**

- I allow _____
To release any/all medical information concerning the named patient above to
Pediatric Care Specialists at Pediatric Care Specialists' request**

I voluntarily give my consent to release any information including treatment instructions/advice that may be in my child's chart or questions that may need response when I am not able to be reached.

I understand that Pediatric Care Specialists cannot release any information without a written consent from the biological parents/legal guardian.

Signature _____

Date _____

This consent expires one year from the date signed/completed