PATIENT INFORMATION

Name: ___________________________________ **Date of birth:** ________________
Sex assigned at birth: ☐ Female ☐ Male ☐ Intersex
Phone number: ___________________________ **Email:** ___________________________________
Reason for Visit: ____

GENERAL CONSENT FOR MEDICAL TREATMENT OF MINOR

I hereby authorize RIVER Pediatric Clinic to provide my child with simple, common, and routine medical services such as those listed below, to the extent my consent is required by law. I understand that under federal and state laws there are certain services that my child may receive that do not need my consent.

Consent must be given for the following services:

1. Diagnosis and treatment of minor and acute illnesses	8. Vision and hearing screening
2. Diagnosis and treatment of mental health issues	9. Laboratory Services
3. First aid for minor injuries	10. Limited x-ray services
4. Physical examinations	11. Over-the-counter items/Prescriptions
5. Assistance with chronic ongoing illnesses, such as: asthma, diabetes, and epilepsy	12. Diet and weight control programs
6. Treatment of acne and other skin problems	13. Referral for health care services that cannot be provided at the Health Center
7. Immunizations	14. Emergency treatment

1. I understand that this consent only applies to services provided at RIVER Pediatric Clinic (RPC) or another Student Run Clinic which is a result of a referral made by the RIVER Pediatric Clinic and does not allow any other private or public facility to provide services to my child.
2. I hereby authorize RPC to give my insurance carrier(s) medical or dental record information needed to complete my child's insurance claims.
3. I understand that my child's medical and/or dental records, including immunization records, will be kept confidential but that this information may be shared with other health care providers for purposes of my child's care and treatment. No other release of my child's health information is allowed without written permission by me, except as permitted or required by law. I understand that RPC's privacy policy is published in the RPC Notice of Privacy Practices.
4. I understand that this consent may be revoked, restricted or revised at any time in writing by me, however, this will not affect services and/or treatment previously provided by RPC and other prior reliance by RPC on this consent. This Consent Form remains in effect until my child turns 18, or until revoked in writing.

Signature of Parent/Legal Guardian/: ______________________________________ Date: ___________
Printed Name: ____

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT

Name of Patient: _______________________________________ Birth Date: ________

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?
❒ YES ❒ NO
May we leave a message on your answering machine at home or on your cell phone?
❒ YES ❒ NO
May we discuss your medical condition with any member of your family?
❒ YES ❒ NO

If YES, please name the member(s) allowed:
____
____

This consent was signed by: ____
(PRINT NAME PLEASE)

Parent/Guardian Signature: ____
Date:_________________