505 E Jefferson Street, Suite A, Bluffton, OH (419) 549-5865

Treatment Consent

I (we), _____, as parent(s) or legal guardian(s) of _____, a minor born on: _____/_____/_____, who resides with me(us) at: _____, hereby authorize the following person(s) to bring the above named minor child to Bluffton Pediatrics, consent to any necessary examination, consultation, and treatment to be rendered to the above named minor child under the supervision of the healthcare team employed by Bluffton Pediatrics, and receive or discuss any medical care about the above named minor child with any of the healthcare team employed by Bluffton Pediatrics:

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____

I (we) further understand that if the above named minor child attends his/her appointment with someone who is not listed herein as an authorized designee, the above named minor child will not be treated and the appointment will need to be rescheduled OR obtain verbal consent from Parent/Guardian. This is for the duration of the above named minor child's care with Bluffton Pediatrics.

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my child's health care, Bluffton Pediatrics maintains my child's electronic records describing his/her health history, symptoms, exams, diagnosis, treatment, plan of care for future treatment, immunizations, & test results. I understand this information is:

1. For planning my child's care & treatment; including electronic prescribing
2. A way to communicate with other healthcare professionals who are a part of my care
3. A source of information for applying my diagnosis & surgical information to my bill
4. A means for third party payers to verify that services billed were actually provided
5. A way to assess quality of healthcare operations & reviewing the competency of the healthcare professionals

I understand that Bluffton Pediatrics is required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand that by refusing to sign this consent or revoking this consent, Bluffton Pediatrics may refuse to treat my child as permitted by Section 164.520 of the Code of Federal Regulations. I further understand that Bluffton Pediatrics reserves the right to change their notice & practices prior to implementation in accordance with Section 164.520 of the Code of Federal Regulations. Should Bluffton Pediatrics change their notice, the will send a copy of the revised notice to the address I have provided via U.S. mail or via the Patient Portal.

I understand that as part of this treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

CONSENT

I certify that I speak, read, and write English, have read and understand this form:

_____ Date: _____/_____/_____

(Parent/Legal Guardian Signature)

_____ Date: _____/_____/_____

(Witness Signature)