NOTICE OF PRIVACY AND CONFIDENTIALITY POLICY
GENERAL CONSENT TO TREAT
CONSENT TO IMMUNIZE

As the parent/guardian of _____, I acknowledge that I have read this form, that I understand it, and that I agree, acknowledge, and consent as indicated below:

_____ I acknowledge that I have received a copy of the Privacy and Confidentiality Policy at The Pediatric Clinic and that I have been given the opportunity to review it.

_____ I consent to allow The Pediatric Clinic to use and disclose my child's personal health information for treatment, billing, and health care operations.

_____ I acknowledge that this notice has been issued and is considered effective on the date signed.

_____ I acknowledge that I have the legal right to consent to medical treatment for this patient.

_____ I voluntarily authorize and consent to such medical care, treatment and diagnostic tests that The Pediatric Clinic and its physicians, associates, nurses, technicians, staff, assistants, or health care providers believe are necessary for this child.

_____ I understand and acknowledge that by signing this form that I am giving permission to the physicians, nurses, physician assistants, and other health care 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.

_____ I voluntarily authorize and consent to the immunization of this child.

_____ I acknowledge that I have read this form or this form has been read to me in a language that I understand.

_____ I have had the opportunity to ask questions about this form and the express acknowledgments and consents contained on this form.

_____ _____

Signature of Parent/Guardian

Signature of The Pediatric Clinic Representative

Date:_____

Date:_____