

# PEDIATRIC ASSOCIATES OF MEDFORD

## PATIENT PRIVACY CONSENT FORM

With my consent, Pediatric Associates of Medford, may use and disclose Protected Health Information (PHI) about my child to carry out treatment, payment and health care operations. Please refer to our practices Notice of Privacy Policy.

I understand, Pediatric Associates of Medford, may continue its current policy to call/mail to my home or other designated location, and leave/send information that assists in the care and treatment of my child.

In the event I am unavailable, the following are allowed to accompany my child for medical treatment:

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Name \_\_\_\_\_

Relationship \_\_\_\_\_

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Print Parent/Legal Guardian Name

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date