

Drs. Lerch, Amato & Associates: Pediatric & Adolescent Medicine

Acknowledgement of HIPAA and Consent for Treatment

1. Acknowledgement of Receipt of Notice of Privacy Statement (HIPAA)

I, _____ have received a copy of Drs. Lerch, Amato & Associates Notice of Privacy Practices. (HIPAA)

Signature of Parent or Legal Guardian

Relationship to Patient

Date

2. Consent for Telephone Confirmations, Releasing and Obtaining Medical Information

In the course in the treatment of the patient, the following will be necessary:

- 1.) Confirm appointments by phone
- 2.) Leave messages on voice mails (answering machines) confirming appointments
- 3.) Release medical information requested by a specialist or other treating physician
- 4.) Give permission for Drs. Lerch & Amato to request records as needed from other physicians and/or institutions to assist in the ongoing treatment of the patient.

I, _____ give my permission to Drs. Lerch, Amato & Associates to do the above.

Name of Patient's Parent or Legal Guardian

3. Consent for Your Child's Caretakers to Seek Medical Care

The following person is authorized to bring in my child for a visit, make medical decisions on my child's behalf, is able to receive medical information in the event I cannot be available. This means that we will order tests as appropriate, and provide recommended immunizations if this caretaker consents to this, and act as if you personally consented to this course of treatment for your child.

Contact Name: _____ Relationship of Contact: _____

Name of Caretaker Grandparent, Sibling, Babysitter

Consent Given By: _____ Date: _____

Name of Parent or Legal Guardian (Signature)

4. Consent for your Teenagers to Seek Medical Care

If a teenaged minor (typically a 17 year old who can drive alone) comes to our office alone, and asks to be treated, we will proceed with treatment. Any PHI that results from this visit will be treated the same as PHI that results from a visit at which you are present. This means that we will proceed to do a medical history, perform an appropriate examination and treat the minor as if you were present. We will order tests as appropriate, and provide recommended immunizations if the minor consents to this.

I give consent of treatment of my teenaged minor to be treated

Name of Teenager

Name of Parent or Legal Guardian (Signature)

Date