Bay Pediatric Clinic P.C.
Revised 03/02/2015

PATIENT CONSENT FORM

This form is for multiple authorizations. Please be sure to read it completely and ask the receptionist if you have any questions.

1. Consent for the release of Demographical information and to include relevant medical information to Early On or Project Find.
2. Consent for the administration and release of immunizations to be put on the MICR (state registry)
3. Consent for the release of medication history from other medical providers
4. Consent to authorize the physician/ his associates to use or disclose personal health information to provide medical or minor surgical treatment, including but not limited to diagnostic procedures, X-rays, medication.
5. I authorize Bay Pediatric Clinic, P.C. to release to any third party payer, or its representatives which may be responsible for payment of my treatment.
6. I hereby assign payment directly to Bay Pediatric Clinic, P.C. of the insurance benefits otherwise payable to me but not to in exceed the balance due to Bay Pediatric Clinic, P.C.
7. I assume full financial responsibility for payment of all services provided to my child, including any portion of my bill that is not paid by my insurance company. I have read and understand the financial policy.
8. I understand that any health related papers that are given to me from Bay Pediatric Clinic, P.C. is my responsibility to maintain confidentiality and keep the protected health information secured.
9. Consent for treatment in my absence will be on file in my child's chart.
   (Please ask receptionist for consent form)
10. Bay Pediatric Clinic, P.C. has the right to use and disclose your PHI for all activities that are included within the definitions of "treatment", "payment" and "health care options" as defined in the HIPPA privacy rule.
11. Bay Pediatric Clinic, P.C. may disclose your PHI to any physician or other health care provider involved with the medical services provided to you. This includes disclosure of your PHI to other healthcare providers through electronic exchanges such as patient registries and Health Information Exchanges (HIEs).
12. I understand that this consent form covers multiple authorizations and therefore this consent shall carry in effect from the date of my signature until I terminate this agreement in writing.

***By placing your signature on this form you are acknowledging that you have received our Privacy Policy and HIPPA Policy and Procedures.** If you would like a copy to take home ask the receptionist.

Print Child's Name:____

Parent/Guardian Signature:____________________________**Date:**________________