Patient Communication & Medical Treatment Authorization Consent Form

Patient Full Name (PLEASE PRINT) _____ **Date of Birth** _____

A. MEDICAL TREATMENT AND CONSENT - This is used when minors are unaccompanied by either parents or legal guardians. This "Medical Treatment Authorization and Consent" gives authority to a designated adult to arrange for medical care for a minor. Medical care cannot be provided to a minor without approval by the parents or legal guardians, unless there is written consent authorizing an agent to give approval.

For the above named patient and for this section "A", you authorize the following people to accompany your minor child to obtain medical care from Ellicott City Pediatric Associates PA. (Please list first and last name)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

B. PATIENT COMMUNICATION - It is the office policy of Ellicott City Pediatric Associates, P.A., not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

For the above named patient and for this section "B", you authorize Ellicott City Pediatric Associates PA to release medical information to the following people. This can include family members, friends, caretakers, etc. (Please list first and last name).

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

By signing below, this grant of temporary authority shall begin on the date signed and shall remain in effect until terminated by the undersigned or until there is a change in the legal status of the patient.

Parent or Guardian Signature_____ **Date:** _____
Print Name _____ **Contact Phone#** _____

FOR OFFICE USE:

Changes to above authorize by patient over phone:	Date	Staff Initials
_____	_____	_____
_____	_____	_____