Commonwealth Pediatrics
1780 Nicholasville Rd., Suite 301
Lexington, KY 40503
Phone: (859) 277-6636
Fax: (859) 277-1455

Consent to Treat/ Medical Records/ Privacy

I, _____, the parent/legal guardian of the below named child(ren),

Child's First & Last Name	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____

(Until we are notified in writing, Commonwealth Pediatrics will assume that a child's biological &/or legal parents are both legal guardians who have access to treatment options and medical information for that child.)

hereby authorize and consent to the examination and/or treatment of my child(ren) during office and facility visits by the providers and clinical staff of Commonwealth Pediatrics, (CWP). In addition, I give permission for the following person(s) to bring my child to CWP in my absence and to act on my behalf in authorizing medical care and treatment. In the event of an emergency or other illness, I understand that the providers and staff of CWP will deliver any medical care deemed necessary regardless of the accompanying adult.

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

***Anyone not mentioned above who brings your child in to the office for treatment must have a signed authorization from the child's legal guardian.*

Medical Records/Privacy

At Commonwealth Pediatrics, we are committed to protecting the security and privacy of your child's personal information. Medical records are the property of Commonwealth Pediatrics, kept in a secure location, and are accessed for only purposes outlined by the Notice of Privacy Practices. By signing below, you authorize CWP to use or disclose your child's protected health information for treatment, payment, or healthcare operations. Patients are entitled to one free copy of their medical records only after an authorization for release is signed. Additional copies may be requested for a reasonable cost based fee.

I acknowledge that I have received Commonwealth Pediatrics' Notice of Privacy Practices and Consent to Treat information. I understand that I have the right to revoke this consent, in writing, at any time.

_____ _____
Parent/Legal Guardian Signature Date

_____
Printed Name