Commonwealth Pediatrics, P.S.C.

Consent to Treat/ Medical Records/ Privacy

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

Child's (1st & Last) *Name*	*Date of Birth*	*Child's* (1st & 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 physicians and clinical staff of Commonwealth Pediatrics. In addition, I give permission for the following person(s) to bring my child to CWP in my absence and to act in my behalf in authorizing medical care and treatment in my absence. In the event of an emergency or other illness, I understand that the physicians 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(ren)'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 CWP, kept in a secure location, and are accessed for only purposes outlined by the Notice of Privacy Practices. Records may be released or shared with other health care providers for treatment of your child. Patients are entitled to one free copy of their medical records only after an authorization for release is signed. Additional copies may be made for a fee of $1.00 per page

⇒I understand that CWP may call my home & place of employment for healthcare reasons, appointment reminders, to resolve billing issues, and may mail informational postcards to my home address, as well as billing information requested verbally by me.

⇒I understand that CWP may leave messages on my answering machine regarding appointments and limited lab information.

⇒I understand that CWP may use an email address provided by me to communicate appointment, billing issues, immunization certificates or other forms requested by the parent.

⇒I authorize CWP to email or fax immunization certificates and/or school forms to my personal or work fax, or mail to my home.

⇒I authorize CWP to discuss patient information with adults or other minors present during the visit regardless of whether I am present.

⇒I understand that if I send a picture of myself or child(ren), CWP may display it within the office.

I acknowledge that I have received Commonwealth Pediatrics' Notice of Privacy Practices and Consent to Treat information. I understand that I can edit any of the above items.

_____ _____

Parent Signature **Date**