PEDIATRIC ASSOCIATES OF HAMPDEN COUNTY, INC.

CONSENT FOR PARENTS TO OBTAIN INFORMATION/MAKE APPOINTMENTS

PATIENT NAME: ______________________________ DOB: ____________

I give my parents/guardians __________________________ permission to make appointments and obtain health information, unless otherwise noted, when I am unable to do so. I understand that without an expiration date noted, the authorization will expire in 90 days after signature/date on form.

□ RELEASE OF SENSITIVE/CONFIDENTIAL INFORMATION
I understand that my medical record may contain information about drug and/or alcohol abuse, psychiatric illness, sexual transmitted disease, social service, hepatitis B testing/treatment and/or sensitive/confidential information. I agree to the release of this information, YES NO
PATIENT SIGNATURE: ____________________________ DATE: ____________

□ RELEASE OF HIV INFORMATION
I understand that my medical record may contain information about HIV (AIDS) testing/treatment. I agree to the release of this information. YES NO
PATIENT SIGNATURE: ____________________________ DATE: ____________

□ MENTAL HEALTH
Any information pertaining to Mental Health.
I agree to the release of this information. YES NO
PATIENT SIGNATURE: ____________________________ DATE: ____________

PATIENT PHONE # ____

PARENT #1/GUARDIAN #1 PHONE # ______________________________

PARENT #2/GUARDIAN #2 PHONE # ______________________________

PATIENT SIGNATURE ____

TODAY'S DATE: ______________ EXPIRATION DATE: ________________

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