Tan & Garcia Pediatrics, P.C.

Consent to Treat and
Authorization to Disclose Protected Health Information

Please complete this form so that, in the event you cannot bring your child to an appointment, another adult that you authorize can bring him/her to the appointment and receive information about his/her care.
Do not list step parents below, instead please complete step parent information on the reverse side of this form.

I, _____, the parent/legal guardian of
(name of parent/legal guardian)

_____
(name of child(ren))

Hereby authorize the individual(s) below to accompany my child(ren) to visit(s) at Tan & Garcia Pediatrics, and consent to the examination and/or treatment and disclosure of medical information regarding the initial and/or follow-up care of my child(ren) during the visit(s).

_____ _____
(name of person authorized to bring child **OTHER THAN PARENT**) (relationship to child)

_____ _____
(name of person authorized to bring child **OTHER THAN PARENT**) (relationship to child)

_____ _____
(name of person authorized to bring child **OTHER THAN PARENT**) (relationship to child)

_____ _____
(name of person authorized to bring child **OTHER THAN PARENT**) (relationship to child)

The above named individual(s) are hereby authorized to have access to my child's entire medical record. I understand that this disclosure will include (check if applicable):

{ } Information relating to AIDS or HIV infection
{ } Treatment for substance and/or alcohol abuse or dependency
{ } Psychotherapy notes, or other information relating to mental health or psychiatric care

This information is being disclosed to the above listed person(s) from records whose confidentiality may be protected by the Pennsylvania Confidentiality of HIV Related Information Act. My signature below authorizes the release of information protected by these Pennsylvania statues. I understand that I have no obligation whatsoever to disclose information from my child's record, and that Tan & Garcia Pediatrics cannot withhold treatment from my child based upon my failure to execute this authorization, unless the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information. I understand that I may revoke this authorization at any time in writing, except to the extent that action based on this authorization may be subject to re-disclosure because it is no longer protected by federal privacy laws. I fully understand the contents of this authorization and voluntarily consent to the release of the information as stated. Tan & Garcia Pediatrics, its employees, officers and clinical staff are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. Finally, I understand that I am entitled to obtain a copy of this authorization from Tan & Garcia Pediatrics upon request.

This Consent/Authorization:

_____ is effective until revoked by me in writing

_____ is effective from _____, 20____ to _____, 20____

_____ is effective only on _____, 20____

_____ _____
Signature of Parent/Legal Guardian **Date**

_____
_____

(name of step parent authorized to bring child **OTHER THAN PAERNT**) (relationship to child)

_____
_____

(name of step parent authorized to bring child **OTHER THAN PARENT**) (relationship to child)