TRIANGLE PEDIATRIC CENTER

Acknowledgement of Receipt of Notice of Privacy:

I, _____ have received a copy of Triangle Pediatric Center's Notice of Privacy
Name of Patient/Parent/Legal Guardian

Practices.

_____ _____ _____
Signature of Patient/Parent/Guardian Relationship to Patient Date

Consent for Your Child's Caretakers to Seek Medical Care:
If someone you have entrusted with the care of your minor child, such as:

- ❑ Grandparents
- ❑ Caretakers (nannies or babysitters)
- ❑ Siblings
- ❑ Other Adult Relatives

brings your child to the office and asks for the child to be treated, we will act as if you personally had consented to treatment for your child. Any Protected Health Information (PHI) that results from this visit will be treated the same as PHI that results from a visit at which you are present. This means that we will proceed to do a medical history, perform an appropriate examination and treat the child as if you were present. We will order tests as appropriate, and provide recommended immunizations if the caretaker consents to this. This also means that the caretaker will have access to PHI that results from this visit, and have access to any other PHI that we may need to use to appropriately care for your child. In this circumstance,

I GIVE CONSENT
to Treatment and to Release of PHI

_____
Signature Date

I REFUSE to Consent
to Treatment and
REFUSE Permission to Release PHI.

_____
Signature Date

Consent for your Teenagers to Seek Medical Care:
If a teenaged minor (typically a 16 year old who can drive alone) comes to our office alone, and asks to be treated, we will proceed with treatment. Any PHI that results from this visit will be treated the same as PHI that results from a visit at which you are present. This means that we will proceed to do a medical history, perform an appropriate examination and treat the minor as if you were present. We will order tests as appropriate, and provide recommended immunizations if the minor consents to this. In this circumstance,

I GIVE CONSENT
to Treatment

_____
Signature Date

I REFUSE to Consent
to Treatment.

_____
Signature Date