Hilliard Pediatrics, Inc.

Consent for Release of Information

Patient Name: _____ DOB: _____

Test/Lab Results:

Please indicate where we are allowed to attempt to contact you with test/lab results:

Primary Contact: _____

☐ Home _____

☐ Cell _____

☐ Work _____

Secondary Contact *(if applicable):*

☐ Home _____

☐ Cell _____

☐ Work _____

Many times when we call, we reach an answering machine or voicemail. Are we allowed to leave a detailed message with test results? ☐ Yes ☐ No, please leave a generic message

Note: Test results of a sensitive nature will ONLY be given directly to the parent/guardian, except where prohibited by law.

Billing/Financial Information:

There are occasionally situations in which we need to contact you regarding your insurance, payments, or past due statements. Please indicate your preferred number(s) to be reached:

Primary Contact: _____

1st # _____

2nd # _____

Secondary Contact *(if applicable):*

1st # _____

2nd # _____

Many times when we call, we reach an answering machine or voicemail. Are we allowed to leave a detailed message with patient names and specific balances? ☐ Yes ☐ No, please leave a generic message

Consent By Proxy – Anyone who is permitted to make and/or bring your child in for appointments and receive medical advice (other than parent/guardian)

I hereby authorize Hilliard Pediatrics, its representatives, physicians, and staff to share any and all relevant medical and financial information including outstanding balances to the following individual(s). The individuals listed below have authorization to bring my child into that office for, and consent to, treatment, or receive medical advice over the phone if they are taking care of my child in my absence. I understand that it may be necessary to perform diagnostic tests in the course of the evaluation and accept responsibility for payment. All copays are still due at the time of service, regardless of who brings the child in for an appointment.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If there are any services that you do not consent to in your absence, please list:

_____

_____

In the absence of written authorization for medical services, our office will try to reach you for verbal authorization. If we cannot reach you, we will not refuse treatment if we feel the situation is emergent enough to warrant. This serves as consent for medical treatment we deem as medically necessary and appropriate.

I have read this form and certify that I understand its contents.

Printed Name: _____ _____ Date: _____

Mother, Father or Legal Guardian *Signature*

A VALID PHOTO ID MUST PRESENTED TO PROVE IDENTITY OF SIGNER

For office Use Only:

Guardian's Identity Verified By: _____ ID Type: _____ Date: _____