

**PEDIATRICS WEST, P.C.**

**CONSENT OF PARENTS/GUARDIANS OF MINOR PATIENTS  
TO DISCLOSE HEALTH INFORMATION FOR PAYMENT,  
TREATMENT AND HEALTH CARE OPERATIONS**

Patient Name: \_\_\_\_\_  
Last First Middle

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
(City) (State) (Zip)

Primary Phone Number: \_\_\_\_\_ Secondary Phone Number: \_\_\_\_\_

Parent's e-mail: \_\_\_\_\_ **Patient's PCP** \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF PEDIATRICS WEST'S (the "PRACTICE") NOTICE OF PRIVACY PRACTICES:**

By my signature below, I hereby acknowledge that I have received a copy of the Practice's Notice of Privacy Practices.

**CONSENT TO DISCLOSE MY CHILD'S GENERAL HEALTH INFORMATION:**

By my signature below, I hereby authorize the Practice to disclose my child's medical information so that the Practice may treat my child, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations (e.g. quality assurance). I also authorize the Practice to disclose my child's medical information to insurers and providers outside of the Practice when necessary so that these providers may treat my child; seek payment for that treatment, and for the purpose of their health care operations. I also authorize the Practice to disclose my child's medical information on my home answering machine or voicemail.

The following family members/friends have my permission to accompany my child to his/her medical appointment: (please list only people over the age of 18 and their relationship to the patient. For example: Tom Jones, grandfather)

None

_____	_____	_____	_____
Name	Relationship to patient	Name	Relationship to Patient
_____	_____	_____	_____
Name	Relationship to Patient	Name	Relationship to Patient

**ASSIGNMENT OF INSURANCE BENEFITS:**

By my signature below, I authorize medical benefits to be paid to Pediatrics West, P.C. on my child's behalf for any service provided by the medical and clinical staff of the practice. I understand that I am responsible for all charges not covered by insurance for this service date as well as all future service dates.

**ASSIGNMENT OF RECEIPT OF PRACTICE'S NOTICE OF THE BILLING POLICY:**

By my signature below, I hereby acknowledge that I have received a copy of the Pediatrics West Patient Policies.

\_\_\_\_\_  
Signature Relationship to Patient Date

\_\_\_\_\_  
Print Name