WATCHUNG PEDIATRICS

www.watchungpediatrics.com

CONSENT TO DISCUSS MEDICAL NFORMATION AND PROTECTED HEALTH INFORMATION OF A PATIENT UNDER 18 YEARS

Patient Name (please print):_____ **Date of Birth:**_____

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With my prior consent, I authorize Watchung Pediatrics to discuss my child's medical information as follows (Initial all that apply):

- Immunization records to be released by fax or mail to: _____School _____Other
- Treatment plans (i.e.: Medication, asthma, epi-pens, etc.) to be disclosed to: _____School _____Other
- Labs and test results _____School _____Other
- Other (Specify): _____ To whom: _____

I further authorize Watchung Pediatrics to release the information to the following (i.e. babysitters, daycares, relatives):

_____
Name of Person Relationship

_____
Name of Person Relationship

_____
Name of School

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity. I hereby consent to such disclosure for these permitted uses. I also hereby consent to such disclosures via fax.

I fully understand and accept the terms of this consent.

_____ _____ _____
Signature Date Parent Cell Phone

I understand that I may revoke this consent at any time and I must notify Watchung Pediatrics in order to revoke the consent.

_____
(Signature of Parent) (Date Signed)

_____
(Printed name of signature above) (Phone Number)

REVOKE CONSENT

(Do not sign below unless you are revoking the above consent)

I hereby revoke the above consent effective immediately. I understand that revoking this consent means that my medical information and protected health information will no longer be discussed or disclosed (released) to the above individuals and that a new consent will need to be completed if this changes.

_____
(Signature of Parent) (Date Signed)