JDC Pediatrics

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, a stepparent or another adult that you authorize can accompany the child and receive information about his/her care.

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

_____
(name of child)

hereby authorize the individual(s) below to accompany my child to appointments at JDC Pediatrics, consent to my child's care, and sign forms relating to my child's care.

Stepmother:

Name_____DOB_____Phone_____

Address_____Employer_____Occupation_____

Stepfather:

Name_____DOB_____Phone_____

Address_____Employer_____Occupation_____

Others authorized to bring child (OTHER THAN PARENT OR STEPPARENT):

_____ _____
(name) (relationship to child)

_____ _____
(name) (relationship to child)

_____ _____
(name) (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 information relating to AIDS or HIV infection, treatment for substance and/or alcohol abuse or dependency, and 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 JDC 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. JDC, 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 JDC 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**

Revised 11/8/18