



HIPAA Acknowledgment & Consent to Treat Form

Patient Information

(List all children covered by this consent)

1. **Patient Name:** _____ **DOB:** _____
2. **Patient Name:** _____ **DOB:** _____
3. **Patient Name:** _____ **DOB:** _____
4. **Patient Name:** _____ **DOB:** _____

Authorized Adults (other than parents)

The following individuals are permitted to bring the child(ren) listed above to appointments and consent to treatment in my absence. They will be required to show Identification at the time of the appointment.

1. **Name:** _____ **Relationship:** _____
2. **Name:** _____ **Relationship:** _____
3. **Name:** _____ **Relationship:** _____

Consent to Treat

I give permission for the providers and staff at this practice to evaluate and treat the patient(s) listed above. This includes physical exams, procedures, and necessary medical services. I also give permission for the authorized adults listed to consent to routine care and treatment for the child(ren) listed.

HIPAA Privacy Acknowledgment

I understand that the practice may use and disclose my child's health information for treatment, billing, and healthcare operations as allowed by law.

I acknowledge that I have received, or have been offered, a copy of the HIPAA Privacy Notice.

Parent/Guardian Name Signature: _____ **Date:** _____

