Mack And Poole Pediatrics PLC

Consent to Treat/Medical Records/Privacy

I, _____________________________________, the parent/legal guardian of the below named child(ren),

Child's (1st & Last) Name	*Date of Birth*	*Child's (1st & Last) Name*	*Date of Birth*
____________________	___________	_______________________	___________
____________________	___________	_______________________	___________

(Until we are notified in writing, Mack & Poole Pediatrics will assume that a child's biological &/or legal parents are both legal guardians who have access to treatment options and medical information for that child)

Hereby authorize and consent to the examination/treatment of my child(ren) during the office and facility visits by the physician and clinical staff of Mack & Poole Pediatrics. In addition, I give permission for the following person(s) to bring my child to Mack & Poole Pediatrics in my absence and to act in my behalf in authorizing medical care and treatment.
In the event of an emergency or other illness, I understand that the physicians and staff of Mack & Poole Pediatrics will deliver and medical care deemed necessary regardless of the accompanying adult.

Name: ____ Relationship: _______________________

Name: ____ Relationship: _______________________

Name: ____ Relationship: _______________________

*** Anyone not mentioned above who brings your child in to the office for treatment must have a signed authorization from the child(ren)'s legal guardian.*

Medical Records/Privacy

At Mack & Poole Pediatrics, we are committed to protecting the security and privacy of your child's personal information. Medical records are the property of Mack & Poole Pediatrics. These records are kept in a secure location, and are accessed for only for the purposes outlined by the Note of Privacy Practices. Records may be released or shared with other health care professionals for the treatment of your child. Patients are entitled to one free copy of their medical records only after and authorization for release is signed. Additional copies may be made for a fee of $1.00 per page.

- By signing below I acknowledge that I have received Mack & Poole Pediatrics' Notice of Privacy Practices and Consent to treat information. I understand that I can edit any of the items below. I understand that MPP may call my home& place of employment for health care reasons, appointments reminders, to resolve billing issues, and may mail me informational postcards to my home address, as well as billing information requested by me verbally to me.
- I understand that MPP may leave messages on my answering machine regarding appointments and limited lab information.
- I understand that MPP may use an email address provided by me to communicate appointment, billing issues, immunization certificates and other forms requested by the parent.
- I authorize MPP to email or fax immunization certificates and/or school forms to my personal or work fax, or mail to my home address provided.
- I authorize MPP to discuss patient information with adults or other minors present during the visit regardless of whether I am present.
- I understand that if I send a picture of myself or child(ren), MPP may display it within the office.

Parent Signature ____ Date _____________________