CRANFORD PEDIATRICS

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

Patient Name:_____ D.O.B_____

Patient Name:_____ D.O.B_____

Patient Name:_____ D.O.B_____

Patient Name:_____ D.O.B_____

With my prior consent,I authorize **Cranford Pediatrics** to discuss my child's medical information as follows(check 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 what information):_____to whom_____

I further authorize Cranford Pediatrics to release the information to the following (I.e, babysitters,daycare's,relatives):

_____
Name of person Relationship

_____
Name of person Relationship

_____
Name of person Relationship

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

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

_____
(Signature of parent) (Date signed)

_____
(Printed name of signature above) (phone number)

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Revoke Consent

(Do not sign below unless you are revoking 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 patient) (Date signed)