Cascade Pediatrics

AUTHORIZATION FOR TREATMENT & RELEASE OF SPECIFIC CONFIDENTIAL COMMUNICATIONS

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

I, _____ as parent or legal guardian of child (children) listed above, authorize the following person (people) to bring my child (children) to Cascade Pediatrics for the following types of visits. *Please include any Step-Parents.

- ❑ Evaluation and Treatment
- ❑ Well Visits
- ❑ Lab Tests
- ❑ Immunizations

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I, _____ as parent or legal guardian of child (children) listed above, authorize Cascade Pediatrics physicians, clinical and administrative staff to disclose the following Protected health information about the child (children) listed above to the following person (people) *Please include any Step-Parents.

- ❑ Medical Care / Treatment: Level of Information: _____
- ❑ Other: (specify in detail) _____ _____
- ❑ Pick up PHI: (Such as prescriptions, billing statements, labs, school forms):
- ❑ Billing Information / Statements

If not previously revoked in writing, this authorization will be in force and effective until its ***expiration in TWELVE (12) months*** from the date of my signature or as otherwise specified here: from: _____ to _____. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at: Cascade Pediatrics 5150 Cascade Rd SE Suite B Grand Rapids, MI 49546. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ Date _____

Patient / Parent / Guardian Signature Relationship: _____