ISLAND PEDIATRICS

CONSENT FOR TREATMENT AND MEDICAL INFORMATION RELEASE FORM

I authorize the examination and treatment of (child's name) _____ by Shelly L. Hall M.D., P.A. (DBA Island Pediatrics) medical staff and such associates they deem necessary. I understand that the examination may include the use of laboratory tests and other non-invasive diagnostic procedures and tests normally provided in a clinic or health facility.

I hereby authorize the health care providers of Island Pediatrics to release and exchange all pertinent medical records regarding my child's treatment to appropriate consulting medical personnel without the necessity of obtaining further permission from me. If I do not authorize the release of this information, I understand the continuity of care could be affected. I agree to assume all responsibility from my refusal to exchange this information and also agree not to hold my physicians or other personnel responsible for any adverse results from my refusal to release this information.

I authorize the release of information for processing health insurance claims, including drug and alcohol use, psychiatric evaluation/treatment and/or AIDS or testing for AIDS (HIV). If I do not consent to the release of this information, I understand that I am personally responsible for all or any part of my bills for treatment.

All medical record information received/released by this office is protected by state and federal confidentiality laws. Any further disclosure of this information is prohibited.

Signature of parent/adult legally responsible for minor child:

X _____

Printed name: _____ Date: _____

Other persons authorized to bring child in for MEDICAL treatment (does NOT include initial visit, well child visits, immunizations, or any other invasive procedures:

Name: _____ Relationship: _____

Name: _____ Relationship: _____