



Consent to Treat / Medical Records / Privacy

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

Name of Child	Date of Birth	Sex
_____	_____	_____
_____	_____	_____
_____	_____	_____

hereby authorize and consent to the examination and/or treatment of my child(ren) during office and facility visits by the physicians and clinical staff of Growing up Children's Clinic, LLC. In addition, I give permission for the following person(s) to bring my child to GUCC in my absence and to act in my behalf in authorizing medical care and treatment. In the event of emergency or other illness, I understand that the physicians and staff of GUCC will deliver any medical care deemed necessary regardless of the accompanying adult. Unless we are notified in writing, GUCC will assume that a child's biological and/or legal parents are both legal guardians who have access to treatment options and medical information for that child.

Name: _____ Relationship: _____ Phone #: _____

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Medical Records / Privacy

At Growing Up Children's Clinic, LLC, we are committed to protecting the security and privacy of your child's personal information. Medical records are the property of GUCC, kept in a secure location, and are accessed for only purposes outlined by the Notice of Privacy Practices. Records may be released or shared with other health care providers for treatment of your child. Patients are entitled to one free copy of their medical records only after an authorization for release is signed.

- I have received a copy of the Notice of Privacy Practices from Growing Up Children's Clinic, LLC.
- I understand that GUCC may call my home and place of employment for health care reasons, appointment reminders and to resolve billing issues.
- I understand that GUCC may use postcards to notify me of appointments or other pertinent information.
- I understand that GUCC may fax immunization certificates, school excuses, physical/sports forms and/or medication instructions to my personal or work fax, or may mail to my home. GUCC cannot fax or send these documents to third parties (schools, daycares, etc.) without a separate, signed authorization form.
- I understand that GUCC may leave messages on my answering machine and/or voicemail regarding appointments and limited lab information.
- I understand that GUCC may discuss patient information with adults or minors present during the visit.
- I understand and agree to all of the above unless I strike through one of the statements.

Signature of Parent / Legal Guardian

Date