PANORAMA PEDIATRIC GROUP

PERMISSION REGARDING INFORMATION CONSENT

Authorization to discuss and disclose information to parents, providers, and others

Patient Name:_____ Date of Birth:_____ Age:_____

I give permission for Panorama Pediatric Group to leave a message/voicemail/text regarding appointment, billing and/or medical information at the following number(s):

Name:_____Phone number:_____ Relationship to patient:_____

Name:_____Phone number:_____ Relationship to patient:_____

Name:_____Phone number:_____ Relationship to patient:_____

I, _____, give permission and authorize Panorama Pediatric Group to discuss or
(parent/guardian/patient over age of 12) disclose health information with the following individuals:
(examples: grandparents, relatives, babysitters, specialist, therapist, psychologist, stepparents, etc.)

Name: _____
First Last Relationship Phone

- ☐ Access medical Information for the patient listed above, including:
  - ☐ ____ (must initial) Mental health information
  - ☐ ____ (must initial) Drug & Alcohol
  - ☐ ____ (must initial) STD & Sexual activity
- ☐ Pick-up and drop off patient* (Payment is due at time of visit; see financial responsibilities below)
- ☐ Attend appointments

Name:_____
First Last Relationship Phone

- ☐ Access medical Information for the patient listed above, including:
  - ☐ ____ (must initial) Mental health information
  - ☐ ____ (must initial) Drug & Alcohol
  - ☐ ____ (must initial) STD & Sexual activity
- ☐ Pick-up and drop off patient* (Payment is due at time of visit; see financial responsibilities below)
- ☐ Attend appointments

Payment toward the co-pay/deductible/co-insurance or balance on patient's account is due at the time of visit no matter who brings patient to visit. Co-pay/deductible/co-insurance payments may be paid ahead of time or on the day of visit by calling #381-4982 or providing to the front desk. A service charge will be added if no payment is made on the day of appointment or within 24 hours of visit.

I understand I may change the above information at any time by sending my written request to PPG. Any change requested does not affect any communication previously made in reasonable reliance on this form. I have had the opportunity to receive and review Panorama Pediatric Group's Privacy Practices.

_____

Printed name of parent/guardian or **patient if over the age of 12***

_____

Signature of parent/guardian or **patient if over the age of 12*** Date