VIVA PEDIATRICS, P.A.©

FROM CRAWLING TO FLYING

MEDICAL RELEASE AUTHORIZATION (HIPAA RELEASE)

I, _____ , authorize the following people to give consent for diagnostic procedures, examination, and treatment to my child. This includes, but is not limited to, lab work (blood/urine), testing for HIV/AIDS, x-rays, and administration of medications ordered/prescribed by the physicians. I consent to electronic retrieval of my medication history via sure scripts or other electronic scripts. This list also includes people who can be reached in an emergency situation.

The duration of this consent is indefinite and continues until revoked in writing.

Print Name	Relationship	Phone Number
Print Name	Relationship	Phone Number

__ I DO authorize anyone listed above to receive any test results and/or medical history

__ I DO NOT authorize anyone listed above to receive any test results and/or medical history

Guardian's Printed Name	Guardian's Signature	Date

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AUTHORIZATION AND CONSENT AGREEMENTS

ACKNOWLEDGEMENT OF HIPAA

I have reviewed the "NOTICES OF PRIVACY PRACTICES" from VIVA Pediatrics, PA and was given the opportunity to ask any questions. I understand that I can request a copy at any time and that I have the right to review the notice prior to signing this consent of agreement

ACKNOWLEDGEMENT OF OFFICE POLICIES

I have reviewed the "OFFICE POLICIES" from VIVA Pediatrics, PA and was given the opportunity to ask any questions. I understand that I can request a copy at any time and that I have the right to review the notice prior to signing this consent of agreement

ACKNOWLEDGEMENT OF E-PRESCRIBING/MEDICATION HISTORY CONSENT

I have reviewed the "E-PRESCRIBING/MECIATION HISTORY CONSENT"" from VIVA Pediatrics, PA and was given the opportunity to ask any questions. I understand that I can request a copy at any time and that I have the right to review the notice prior to signing this consent of agreement

CONSENT TO TREAT

I hereby authorize the physicians and employees of VIVA Pediatrics, PA to render medical evaluations and care of the patient. The duration of this consent is indefinite and continues and continues until revoked in writing. I understand that by not signing this consent, the patient(s) will not be provided medical care except in the case of an emergency

Keeping information private is important to us and by default we will only disclose information related to the patient's Billing Account and Medical Conditions to the parent or legal guardian. All treatment and medical information will be discussed with **both** biological parents unless otherwise specified.

I have read and understand VIVA Pediatrics Authorization and Consent Agreements. The duration of this consent is indefinite and continues until revoked in writing.

Guardian's Printed Name	Guardian's Signature	Date