Consent to Treat and Notice of Privacy

I, _____, parent or legal guardian of _____ do hereby consent to any medical care and treatment determined by a physician to be necessary for the welfare of my child while said child is under the care of Sunflower Pediatric Clinic, and I am not reasonably available by telephone to give consent.

I understand that by signing this form I consent to the following:

a) **Sharing information for the purpose of treatment**: You will share my child's information with all members of their treatment team, both within this office and with other providers (personal and institutional) in order to provide him/her with quality care and the educational/wellness programs specified in his/her insurance plan.

b) **Sharing information for the purpose of payment**: You will share all necessary information with my child's insurer(s), payer(s), governmental entities (such as Medicare, Medicaid, etc.) and their representatives (including but not limited to, benefit determination and utilization review) as well as your representatives, data warehouse, and billing companies.

c) **Sharing information for the purpose of operations**: You will share all information necessary for ongoing operations of this office (including but not limited to, credentialing process, peer review, accreditation, and compliance with all federal and state laws).

I have reviewed this office's Notice of Privacy as required by the Healthcare Information Privacy and Portability Act, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document. My consent is freely given. I understand that I may revoke this consent at any time of revocation is in writing, but any disclosure given in reliance on the prior consent will be permissible.

_____ _____

Signature of Parent or Guardian Date

_____

Printed Name of Parent or Guardian