Consent to Treat / HIPAA Consent 2009

Please check box if agreed.

☐ 1. **Permission to treat**: I, the undersigned, do hereby give permission to any of the doctors or staff of Eastglen Pediatrics, Inc. to medically treat my child(ren) or wards should they come to Eastglen Pediatrics, Inc. in need of medical attention. This permission to treat extends to: L. Robert Polster, M.D., Cynthia J. Black, M.D., Beth L. Ellingwood, M.D., Ellen K. Kumler, M.D., and Jason W. Mailloux, M.D.

☐ 2. **Voicemail messages**: I also give permission to the doctors and staff at Eastglen Pediatrics, Inc. to leave voicemail messages concerning my child(ren) and lab results. I understand it is my responsibility to inform the office of any changes in this information. Please leave information at the following phone numbers:

Primary # ______________________________ **home work cell other** (*circle one*)
Secondary # ____________________________ **home work cell other** (*circle one*)
Tertiary # ______________________________ **home work cell other** (*circle one*)

☐ 3. **Mailings**: I also give my permission to mail reminder postcards regarding appointments to my home address. I understand it is my responsibility to inform the office of any changes in this information. My address is as follows:

Home Address ____
____
____

☐ 4. **Privacy Policy**: I also acknowledge that I have received a copy of and understand the Privacy Policy Notice from Eastglen Pediatrics, Inc.

My child(ren)'s or ward(s) name(s) is/are:

_______________________________________ DOB _______ / _____ /______
_______________________________________ DOB _______ / _____ /______
_______________________________________ DOB _______ / _____ /______
_______________________________________ DOB _______ / _____ /______
_______________________________________ DOB _______ / _____ /______
_______________________________________ DOB _______ / _____ /______

________________________________ ________________________________
Parent or Guardian Signature Parent or Guardian Signature

________________________________ ________________________________
Relationship to Patient Relationship to Patient

_________________________ _________________________
Date Date