

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