SCH Professional Corporation

Patient Information

Patient's Full Name: ____ **Birthdate:** ____________________

Consent for Treatment

I, ___________________________________, parent/guardian of the above named child, authorize the following individuals to bring my child to see their provider. I also give permission for my provider to provide test results, medical advice and perform any immunizations and/or medical testing necessary.

Name:____ Relationship to child:___________________________

Name:____ Relationship to child:___________________________

Name:____ Relationship to child:___________________________

If you have and questions regarding my child please call the following:

Parent/Guardian Name:____________________________________ Cell/home/work:______________________________

Parent/Guardian Name:____________________________________ Cell/home/work:______________________________

The HIPAA Privacy Act was passed to protect your rights to privacy concerning your medical information. Federal law requires that We have your signature on file in your chart instructing us as to how to handle your medical information. Include the names of any family members, family doctor or other medical personnel that you permit to be informed of your medical information. Do not assume that our staff knows whom we can speak to regarding your medical information.

I, __________________________________, authorize SCH Professional Corporation to provide my medical information to:

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Privacy Practices

I hereby acknowledge that I received the Notice of Privacy Practice of SCH Professional Corporation which sets forth the ways in which my personal health information may be used or disclosed by SCH Professional Corporation, and outlines my rights with respect to such information.

Above authorizations expire one year from date of signature.

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Signature (Parent or guardian if a minor) Date