PEDIATRIC HEALTHCARE
42141 Mound Road
Sterling Heights, MI 48314
P: (586) 254-7593
F: (586) 254-7834

PATIENTS AGE 18 OR OLDER
CONSENT FOR DISCUSSION WITH FAMILY MEMBER AND/OR PERSONAL REPRESENTATIVE
(Excludes CONFIDENTIAL Information – see consent below)

Patient's Name: _____ Birthdate: _____

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for my physician and his/her staff to verbally discuss my personal medical information with the following individual(s):

Name: _____ Relationship to Patient: _____ Phone# _____

Name: _____ Relationship to Patient: _____ Phone# _____

Name: _____ Relationship to Patient: _____ Phone# _____

Authorization:

Patient Signature (required): _____

Date of Signature (required): _____

CONSENT FOR DISCUSSION OF CONFIDENTIAL INFORMATION

Pediatric HealthCare **will not** discuss the following **CONFIDENTIAL** information unless you choose to initial the specific item(s) below.

I authorize the following **CONFIDENTIAL** information to be discussed:

_____ Alcohol / Drug Abuse Evaluation / Treatment

_____ HIV / AIDs / STD Evaluation / Treatment

_____ Psychiatric / Mental Health Evaluation / Treatment

_____ Pregnancy Evaluation / Treatment

Above confidential information can be discussed with the following:

Name: _____ Relationship to Patient: _____ Phone# _____

Name: _____ Relationship to Patient: _____ Phone# _____

Name: _____ Relationship to Patient: _____ Phone# _____

Authorization:

- I authorize Pediatric HeathCare to discuss the information marked above.
- I understand that when the health information is discussed, the information could be shared with others by the recipient and may no longer be protected by federal or state privacy laws.
- I understand that my healthcare and payment for healthcare will not be affected if I do not sign this form.

Patient Signature (required): _____

Date of Signature (required): _____