

Consent to Treatment and Use of Health Information

Consent for Medical Treatment

I allow the healthcare providers of North Reading Pediatrics to give the patient named below medical care, including medical examinations, diagnostic testing or procedures, administration of medications, treatment, and other medical services as determined by the provider. I understand that absent emergency circumstances, major therapeutic and diagnostic procedures will not be performed unless I have had the opportunity to discuss such procedures and the risks associated therewith to my satisfaction and I have consented to such procedure. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantee has been made to me promising any specific result or outcome.

Release of Information for Payment and Assignment of Benefits

I agree that North Reading Pediatrics can share the patient’s health information with the patient’s health plan or other payment source in order to receive payment for services rendered. I hereby assign to North Reading Pediatrics the right to health insurance benefits otherwise payable to me or the patient on account of the care provided, and I authorize such medical insurance benefits to be paid directly to North Reading Pediatrics. I agree to cooperate and provide information as needed to establish my eligibility for such benefits. A copy of this assignment and authorization may be used in place of the original.

Sharing Information Electronically

North Reading Pediatrics may share information electronically with other healthcare providers involved in the patient’s care. Information may be shared using platforms such as the Massachusetts Health Information Highway (Mass HIway), Massachusetts Immunization Information System (MIIS), EpicCare Link, Care Everywhere, and others. I agree that North Reading Pediatrics can use these platforms to share the patient’s medical information. I have been provided with a copy of the North Reading Pediatrics Notice of Privacy Practices that describes other uses and disclosures of health information.

Acknowledgment

This approval will remain in effect until the patient leaves ***North Reading Pediatrics***.

Patient’s Name

Patient’s Date of Birth

Parent/Legal Guardian’s Name (if applicable)

Relationship to Patient

Signature of Parent/Legal Guardian/Self (if 18+)

Date