Pediatrics at Murphy Road
Ylicia Richards, MD
1224 Thomasville Court
Garland, TX 75044
P: 972-414-CUTE (2883) ~ F: 972-414-LOVE (5683)

Consent Form

Patient's Name: _____DOB: _____ Date: _____

General Consent to Treat
I, (name of parent/guardian/patient) _____ have the legal right to consent to medical and surgical treatment for the above named patient. I voluntarily authorize and consent to the medical care, treatment and diagnostic testing that Pediatrics at Murphy Road and their designated associates or assistants believe are necessary for this patient. I understand that by signing this form, I am giving permission to the doctors, nurses, and other healthcare providers in this medical office to provide treatment as long as they are a patient in this office, or until I withdraw my consent in writing.

_____
(Please initial)

Acknowledgement of receipt of Notice of Privacy Practices
I acknowledge that I have received Pediatrics at Murphy Road's Notice of Privacy Practices. The Notice explains how Pediatrics at Murphy Road may use and disclose my child's/my protected health information for treatment, payment and healthcare operations purposes. I understand that "Protected Health Information" is my child's/my personal health information found in their/my medical and billing records. If I have questions about the Notice, I understand that I may contact the Pediatrics at Murphy Road's privacy officer whose contact information is located in the Notice.

_____
(Please initial)

Consent to Release and Obtain Information
In agreement with federal and state law, I agree to allow Pediatrics at Murphy Road to deliver the necessary care to this child/myself in order to provide continuity of care and treatment. Pediatrics at Murphy Road and/or my provider may obtain from any source and examine and use, or discuss and disclose, the patient's/my medical record and information to treating hospital personnel and agents, other healthcare providers, medical records auditors, professional committees, care evaluators and governmental agencies. This information can include, but is not limited to: medical history, examinations, diagnoses, treatments, psychiatric care, except notes from a mental health provider, drug and alcohol abuse, genetic testing information, and HIV or AIDS information. This consent to release and obtain information is valid until revoked. The undersigned may revoke the consent in writing at any time, except with regard to disclosures that have already been made in reliance on such consent.

_____
(Please initial)

Electronic Prescriptions (E-Prescribing)
I voluntarily authorize Pediatrics at Murphy Road to allow E-Prescribing for the patient's/my prescription. I understand that this allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medical dispensing history, as long as this child or I am a patient at this office, or until I withdraw my consent in writing.

_____
(Please initial)

Assignment of Insurance Benefits
I hereby assign, transfer, and set over to Pediatrics at Murphy Road all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

_____
(Please initial)

_____ _____
Printed name of Parent/Guardian/Patient Signature of Parent/Guardian/Patient

Thank you for choosing Pediatrics at Murphy Road!