WRITTEN ACKNOWLEDGMENT OF RECEIPT OF TEXAS CHILDREN'S HOSPITAL INTEGRATED DELIVERY SYSTEM NOTICE OF PRIVACY PRACTICES

______________ (Please initial) I acknowledge receiving the Texas Children's Hospital Integrated Delivery System ("TCH IDS") Notice of Privacy Practices ("Notice"). The Notice explains how TCH IDS may use and disclose your protected health information for treatment, payment and health care operations purpose. "Protected health information" means your personal health information found in your medical and billing records.

If you have questions about the Notice, please contact the TCH IDS Privacy Office. Contact information is located in the Notice.

General Consent to Treat

I am the parent/guardian of (name of patient). I have the legal right to consent to medical and surgical treatment for this patient.

I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that Dr. _________________ and his/her designated associates or assistants believe are necessary for this child. I understand that by signing this form, I am giving permission to the doctors, nurses, physician assistants, and other health care providers in this medical office to provide treatment to this child as long as this child is a patient in this office, or until I withdraw my consent.

______________(Please initial)

Consent to Release and Obtain Information

In agreement with federal and state law, I agree to allow Texas Children's Pediatric Associates (TCPA) to deliver the necessary care to this child in order to provide continuity of care and treatment . TCPA and/or the patient's provider may obtain from any source and examine and use, or discuss and disclose, the patient's medical record and information to treating hospital personnel and agents, other health care 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, any psychiatric, drug and alcohol abuse or genetic testing information, or 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)

____________ (Please initial) I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

Electronic Prescriptions (E-Prescribing)

________________ (Please initial) I voluntarily authorize TCPA to allow E-Prescribing for the patient's mail order prescription, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medication dispense history as long as this child is a patient in this office, or until I withdraw my consent.

Name of Patient: ____ DOB:________
(Date of Birth)

Name of Patient's Representative (Printed):________________________________

Relationship of Patient's Representative: __________________________________

Signature of Patient or Patient's Representative: ____________________________________ Date: _______

Revised July 1, 2011