RAINBOW PEDIATRICS
ANNUAL CONSENT FORM

Patient Name: ___________________________________ **DATE OF BIRTH:_________________**

Communication Authorization

I authorize Rainbow Pediatrics to contact me using the methods listed below in regards to personal health information (including but not limited to, lab and other test results). By providing contact information, I authorize Rainbow Pediatrics, its assignees, and third-party collection agencies to use the contact information I have provided to communicate with me and place calls to my listed methods of contact; leave voicemail or text messages; and use pre-recoded/artificial/voice messages and/or auto-dialing devices in connection with any communication to me. I further understand that Rainbow Pediatrics may also contact through my secure patient portal account. If the office is unable to contact me, I authorize them to send a notice to my home address.

Primary Contact Name:___________________________ Secondary Contact Name:_________________________

Primary Contact #:_______________________________ Secondary Contact #:_____________________________

	Primary		Secondary
☐	Leave Message w/contact number only	☐	Leave Message w/contact number only
☐	Leave message with detailed information	☐	Leave message with detailed information
☐	Do not Leave Message	☐	Do not Leave Message

Permission to Treat for Alternate Caregivers

In my absence, I hereby give my consent to the following individuals to consent to medical treatment for the patient. I understand the caregiver will be required to show photo ID, have current insurance information and payment due for each visit. I understand it is my responsibility to notify Rainbow Pediatrics in writing should the alternate caregiver contact(s) change. I also understand that this consent will expire one year form the signature date and in order to keep alternate caregivers on the account, I must update their information annually.

Below, list the Alternate Caregivers who might bring the patient to the office in the event the primary caregivers (parent/legal guardian) are unable. For example, an extended family member, step parent, nanny, family friend, etc.

Name:_________________________________ DOB:________________RELATIONSHIP_____________________

Name:_________________________________ DOB:________________RELATIONSHIP_____________________

By signing below, I acknowledge that I have read, understand and agree to abide by the statements contained in this document for the above listed patient.

Printed Name of Signor____

Signature of Patient or Guardian ____

Relationship to Patient ____

Today's Date __________________________