RAINBOW PEDIATRICS
GENERAL CONSENT FORM

Patient Name: _____ DATE OF BIRTH:_____

Medical Information

By initialing here, I am agreeing that the person listed below may have access to my children(s) medical records, scheduling and canceling of appointments, viewing treatments, prescriptions and lab results. Your provider at Rainbow Pediatrics, may request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

Initials: _____

Permission to Evaluate Minor Child

By initialing here I am agreeing that the person listed below may bring my child to his/her appointments. Should any medical decisions need to be made, the parent will be contacted prior to any action being taken and if consent is given, a Rainbow Pediatrics associate must be on the phone to acknowledge such permission has been granted. Your provider at Rainbow Pediatrics, may request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

Initials: _____

ePrescribe Program

By initialing here, I am agreeing that your provider at Rainbow Pediatrics, may request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

Initials: _____

Fax

By initialing here, I am agreeing that Rainbow Pediatrics has my permission to fax forms regarding my child to his/her school or daycare provider.

Initials: _____

NOTICE OF PRIVACY PRACTICES

By initialing here, I am agreeing that Rainbow Pediatrics provided me with a written copy of their Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

Initials: _____

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 _____