Patient Name: ____ DOB: ______________________

Patient Name: ____ DOB: ______________________

Patient Name: ____ DOB: ______________________

Patient Name: ____ DOB: ______________________

Online Communications Informed Consent Instructions for using Online Communications:

You agree to take steps to keep your online communications from Steeplechase Pediatrics confidential including: (1) Do not store messages on your employer-provided computer; otherwise personal information could be accessible or owned by your employer. (2) Use a screen saver or close your messages instead of leaving your messages on the screen for passersby to read and keep your password sage and private. (3) Do not allow individuals or other third parties access to the computer(s) upon which you store medical communications.

Notice of Privacy Practices and Consent to Treat:

We may use/disclose information about your child to provide your child with treatment and services. We may use/disclose medical information about you/your child so that the treatment and services your child receives from us may be billed a payment may be collected from you, an insurance company, or a third party. We may disclose, as needed, your child's protected health information in order to support the business activities of the physicians' practice, i.e., we may use a sign-in sheet at the registration desk where you will be asked to sign your child's name and indicate the physician. We may also call you/your child by name in the waiting room when the physician is ready to see you. We may use/disclose your child's health information to provide you with appointment reminders. Other uses/disclosures that can be made without consent or authorization; as required by law enforcement agencies, to avert a serious threat to public health/safety, in response to a legal proceeding, to a coroner or medical examiner for identification of a body as required by the FDA, uses/disclosures in domestic violence/neglect situations, or other public health activities.

Any health care professional authorized to enter information into your child's medical record, all employees, staff and other personnel at this practice who may need access to your child's information must abide by this notice. All subsidiaries, business associates (e.g. laboratory), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this notice. Except where the treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

I have read the consent form and the above information and I accept the conditions listed.

Parent Name | Parent Signature | Date