Geauga Family Physicians

Board Certified Physicians

Pediatric Authorization form for children ages birth – 17 years of age

Patient's Name _____ **Birth Date** _____/_____/_____

Parent(s) or Guardian's Name: _____

Please list any relatives to whom you give approval to discuss your child's medical information with and/or bring your child in for appointments, in the case of your absence (authorization will remain indefinitely unless you revoke in writing).

Name: _____Phone # _____ Relationship to patient _____

Name: _____Phone # _____Relationship to patient _____

Name: _____Phone # _____ Relationship to patient _____

Name: _____Phone # _____Relationship to patient _____

Signature of Person Authorizing Information
Release and Payment Authorization

I understand that sometimes my insurance company does not pay for certain medical care which might include lab work, physicals, or certain procedures. If this happens I will be responsible for payment to Geauga Family Physicians. I understand that if there is no payment after two statements, my child's account will be submitted to a collections agency with an additional $15.00 charge. ***Patient Consent Form of Our Privacy Notice Required by HIPAA*, The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. You have the right to review an explanation of this privacy notice which is located in a folder in our waiting room. I also understand that sometimes my medical information will be sent to specialists, hospitals, or other facilities or pharmacies and I give authorization to Geauga Family Physicians to follow through with my medical care as they deem medically necessary. We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, or other healthcare operations. This is a voluntary agreement. You may opt-out at any time from the Health Information Exchange by notifying our office staff.**

Print name of person completing this form: _____

Signature: _____ Today's Date _____/_____/_____

Relationship to the patient: _____

(Form updated 3/16/2016)