Texas Children's Pediatrics

General Consent to Treat

I have the legal right to consent to medical and surgical treatment because (a) I am the patient or (b) I am the parent/guardian of the patient.

All references to "patient", "me" and "my" in this document means: _____ (name of patient).

I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that the providers at Texas Children's and their designated associates or assistants believe are necessary. I also consent to the taking of photographs or films related to the care and treatment of the patient and understand that such photographs or films may be made part of the medical record. 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 as long as a physician/patient relationship exists, or until **I** withdraw my consent.
_____ (Please initial)

Sharing Records for Treatment

We share medical records electronically with other health care providers to allow and promote continuity of care among providers. If you visit another provider who also participates in an electronic medical system, they may have access to your medical record.
_____ (Please initial)

Voicemail and Text Notifications

As a service to our patients, Texas Children's provides courtesy appointment reminder calls/texts and possibly other important calls that may be placed using a prerecorded auto messaging system. The information may include protected health information. By initialing below, you consent to receiving such calls/texts at the cell phone number you have provided to us.
_____ (Please initial)

Electronic Prescriptions (E-Prescribing)

I voluntarily authorize Texas Children's to allow E-Prescribing for prescriptions, which allows health care providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medication dispense history as long as a physician/patient relationship exists, or until I withdraw my consent.
_____ (Please initial)

Acknowledgment: Notice of Privacy Practices

I acknowledge receiving Texas Children's Notice of Privacy Practices ("Notice"). The Notice explains how Texas Children's may use and disclose the patient's protected health information for treatment, payment and health care operations purpose. "Protected health information" means the patient's personal health information found in the patient's medical and billing records. ***If you have questions about the Notice, please contact Texas Children's Privacy Office at (832) 824-2091.***
_____ (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.
_____ (Please initial)

Patient's Name: _____Date of birth (MM/DD/YYYY):_____

Name of Patient's Representative, if patient under 18 (Printed):
_____

Relationship of Patient's Representative if patient under 18:
_____

Signature of Patient or Patient's Representative: _____Date: _____

Updated June 18, 2014