Southdale pediatric associates, ltd.

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AFTER HOURS-EMERGENCIES 952-653-0261

PATIENTS AGE 18 OR OLDER

CONSENT FOR DISCUSSION WITH FAMILY MEMBER AND/OR PERSONAL REPRESENTATIVE
This consent expires in 1 year

(Excludes CONFIDENTIAL Information – see consent below)

Patient's Name: _____ Birthdate: _____Phone#_____

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for my physician and his/her staff to verbally discuss my personal medical information with the following individual(s):

Name: _____Relationship to Patient: _____ Phone# _____

Name: _____Relationship to Patient: _____ Phone# _____

Name: _____Relationship to Patient: _____ Phone# _____

Authorization:

Patient Signature (required): _____

Date of Signature (required): _____

CONSENT FOR DISCUSSION OF CONFIDENTIAL INFORMATION

Southdale Pediatrics **will not** discuss the following **CONFIDENTIAL** information unless you choose to initial the specific item(s) below.

I authorize the following **CONFIDENTIAL** information to be discussed:

_____ Alcohol / Drug Abuse Evaluation / Treatment
_____ HIV / AIDs / STD Evaluation / Treatment
_____ Psychiatric / Mental Health Evaluation / Treatment
_____ Pregnancy Evaluation / Treatment

Above confidential information can be discussed with the following:

Name: _____Relationship to Patient: _____ Phone# _____

Name: _____Relationship to Patient: _____ Phone# _____

Name: _____Relationship to Patient: _____ Phone# _____

Authorization:

- I authorize Southdale Pediatrics to discuss the information marked above.
- I understand that when the health information is discussed, the information could be shared with others by the recipient and may no longer be protected by federal or state privacy laws.
- I understand that my health care and payment for health care will not be affected if I do not sign this form.

Patient Signature (required): _____

Date of Signature (required): _____