Legacy PEDIATRICS

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Consent for Treatment

By signing this consent, I am authorizing Legacy Pediatrics to perform and/or order another person to perform all exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my child's medical condition. This consent is valid for each visit made to Legacy Pediatrics unless revoked by me orally or in writing.

Please be informed North Carolina Law allows a patient to be tested for possible exposure to Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1.) to screen blood, blood products, organs or tissues to determine suitability for donation; 2.) if another individual is accidentally exposed to a patient's blood or bodily fluids, such as a needle stick; 3.) if a medical or surgical procedure is to be performed which could expose healthcare workers to the patient's blood or bodily fluids. This disclosure is to inform you that your child may be tested at the expense of Legacy Pediatrics if any of these situations occur during the treatment period.

Parent/Legal Guardian Signature Date

Authorization for Release of Information

I hereby authorize Legacy Pediatrics to furnish medical information pertinent to my child's medical condition including, but not limited to, the diagnosis, treatment, and care offered or rendered to my child while a patient of legacy Pediatrics. I understand this information will only be furnished: 1.) to my insurer(s) to which my medical bills have been assigned for payment; 2.) as required by law. I understand that my medical information will not be released to any persons other than those named without my express written permission. I also understand that my written permission, my child's entire record including HIV status can be released to the healthcare provider as specified in my written request. Any revocation of this release must be submitted in writing to Legacy Pediatrics.

For the purpose of this release, "medical information" shall mean copies of all medical records, tests, x-rays, reports and/or other materials in the possession of Legacy Pediatrics relating to my child's medical condition and proposed or actual treatment. I understand that by signing this consent I am also authorizing release of any information contained within the medical records which may be released to AIDS and/or HIV antibody or antigen testing to the above mentioned persons.

By signing this consent to release medical information, I agree not to hold Legacy Pediatrics, their agents and employees liable for any unfavorable outcomes as the result of this information. I realize that release of my child's medical information may be necessary before my insurer will cover the cost of my child's medical treatment, and that by failing to authorize the release of this information; I maybe required to pay the entire bill at the time of service.

Parent/Legal Guardian Signature Date

Patient Name Date of Birth