



Eureka PEDIATRICS

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Ted Green, M.D. Douglas Nozaki, M.D.

HIPPA/CONSENT FORM

Patient's Name: _____ DOB: _____

Receipt of Privacy Practices:

Protecting your child/children's privacy and medical information is at the core of our practice. We recognize our obligation to keep your information secure and confidential whether in written, oral or electronic format.

I have been provided with a Notice of Privacy Practices that proves a description of the uses and disclosures of my child/children's personal health information.

Parent/Guardian Signature	Printed Name	Date
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Medical Information Disclosure:

- I authorize Eureka pediatrics to call the primary phone number listed below and leave a message regarding appointment reminders, insurance items. _____ Initial
- I authorize Eureka Pediatrics to use and or disclose pertinent health information about my child/children for school camp or sport forms and securely fax such information as requested by school or parent/guardian. ____ Initial

The phone number provided below is the best number for Eureka Pediatrics to contact me and will be listed as the primary number my child/children's account.

Primary Phone Number: _____ Home Mom Cell Dad Cell

Medical/Consent Information:

I authorize Eureka Pediatrics, its physicians and staff, to share any and all medical information with the following individuals. The individuals listed below are involved in my child's care and have authorization to talk to our staff on the phone and bring my child into the office. The individuals also have my consent to bring my child for immunization and any other medical treatment that may be needed during the office visit if I am not able to be present. **Both parents will automatically have authorization unless court documents are presented specifically stating one is not authorized.**

Please fill out any family members or friends that may bring your child in.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Parent/Guardian Signature	Printed Name	Date
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For children ages 16 and older: I give permission for them to present to Eureka Pediatrics for care without the presence of an adult guardian. This permission will remain in effect until such time that I specifically revoke it.