CARTERSVILLE PEDIATRIC ASSOCIATES, PC
MEDICAL CONSENT FOR PATIENTS 18 YEARS & OLDER

Patient Name: _____ Date of Birth: _____

Patient confidentiality is important at Cartersville Pediatric Associates. Therefore, we ask that you provide us with the following information:

Please list names of any family members or other parties that you authorize to seek medical attention (over the phone or at a scheduled office appointment), speak to nurses, schedule appointments, pick up prescriptions or forms, and/or receive personal health information concerning you:

_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient

o I **DO NOT** authorize anyone other than myself to access my protected health information for **ANY** reason.

In the event that I am unable to be reached at the primary phone number listed in my record, Cartersville Pediatric Associates may leave the following information on my voicemail (check all that apply):

□ Appointment Reminders □ Test Results □ Referral/Test Information □ Financial Information

By signing below, I understand that a written request must be submitted in order to make changes to, revoke or terminate this authorization.

_____	_____
Patient Signature	Date
_____	_____
Signature of Witness	Date

Internal Use Only

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