Walden Pond PEDIATRICS

101 Thoreau Street
Concord, MA 01742
Office: (978) 369-9401
Fax: (978) 371-8810
www.waldenpondpediatrics.com

CONSENT FOR 18+ AND EMANCIPATED MINORS

Name of Patient _____ DOB _____ Today's Date _____

I understand that I am classified as a legal adult under the law. This means that my parents and/or legal guardians may NOT access my health information, under the HIPPA Patient Privacy Acts. In full knowledge of my rights to privacy, I am WAIVING my right to privacy to the following individual(s):

Name _____ Relationship _____

Name _____ Relationship _____

I consent for the following to be discussed with him/her/them (check all that apply):
( ) Confidential Laboratory / Radiology Results
( ) Scheduling and Cancelling of Appointments
( ) Prescription Information (name and indication of prescription, dosing, refills, etc)
( ) Health History
( ) Recent Health Problems
( ) Other _____

CONSENT FOR TELEPHONE CONTACT

I understand that the office will be contacting me at home or the number of my choosing to confirm appointments.

Home Phone _____
Other Phone _____ (Cell / Work)

In addition, I consent for the office to (check all that apply):
( ) Leave a message to report the results of lab test
( ) Leave other messages

CONSENT FOR CORRESPONDENCE BY MAIL

I understand that the office will be sending me correspondence by mail.
In addition, I consent for the office to (check all that apply):
( ) Reminder post cards for annual physical appointments
( ) Laboratory test results
( ) All other correspondence from our office by mail

Signature _____ Date _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name _____ Relationship to patient _____