SUZANNE MILLS, M.D.

AUTHORIZATION CONSENT FORM

PATIENT NAME: ____ DOB: ______________
LAST FIRST MIDDLE

AUTHORIZATION TO TREAT:

Parent/Guardian gives permission to treat child when escorted by someone other than parent/guardian.

______________________________________ ______________________
Parent/Guardian Signature Date

AUTHORIZATION TO RELEASE INFORMATION:

Many of our parents/guardians allow family members, nannies, assistants, etc to call and inquire about tests, procedures and appointment times and billing. Under HIPAA guidelines we are not allowed to release this information without a parent/guardian consent. If you wish to have your child's information released to someone other than yourself please sign this consent form.

I authorize Suzanne Mills Pediatrics to release appointment information, test and procedure results, and billing to the following individuals:

1. ______________________________________ Relation: ______________________

2. ______________________________________ Relation: ______________________

3. ______________________________________ Relation: ______________________

______________________________________ ______________________
Parent/Guardian/Patient Signature Date

AUTHORIZATION TO LEAVE MESSAGE:

This consent allows us to leave messages regarding appointment times, test and procedure results on the following answering machines and voice mails:

Home: __________________ Cell: __________________ Work: __________________

______________________________________ ______________________
Parent/Guardian/Patient Signature Date

You have the right to revoke the above consents in writing.
Prior disclosures will not be affected.