



9211 Forest Hill Ave, Suite 204
Richmond, VA 23235
T/F (804) 977-2634
www.richmondnaturalmed.com

Pediatric - New Patient Intake

Child's Full Name: _____ Preferred Name: _____ Date: ___/___/___

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home _____ Cell _____ Other: _____

E-mail address(es): _____

Date of Birth: ___/___/___ Age: _____

Lives with (check all that apply): Parents Siblings - If so, how old are they? _____ Other _____

Parent(s)/Guardian Name: _____

Emergency contact: _____

Relationship: _____ Phone: _____

Address: _____

How did you hear about our clinic? _____

When did the child last receive healthcare? _____

What is/was the reason? _____

Who is the child's pediatrician? _____ Phone _____

Does the child currently have any contagious diseases? Yes No Please list: _____

What are your most important health concerns and what treatments have been used?

1. _____ treatments used _____

2. _____ treatments used _____

3. _____ treatments used _____

What service(s) are you here for today? _____

I give the professionals at RNM permission to assist in my care. I understand that such professionals may include RNM employees, members, and independent contractors. I agree to indemnify and hold harmless RNM, its officers, members, independent contractors, directors, and employees from any and all damages and/or liability arising out of or related to services rendered. I also understand that if I do not give a 24-hour notice for an appointment cancellation or if I do not show for the appointment, I will be charged an insufficient notice fee.

_____/_____/_____
SIGNATURE DATE



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Height: ____' ____" Weight: ____ lbs. Gender: ___ Male ___ Female ___ Transgender ___ Other

Blood Type: ____ Unknown Has your child gone through puberty: Yes No. If so, at what age? ____

Is there any other information about your child's health that you'd like us to know? Please include if this information can be discussed in front of your child. _____

GOALS

What is your primary concern for your child's health?

What additional concerns would you like to address?

What led you to choosing this clinic?

What do you know about us and how we work?

What expectation(s) do you have for today's visit at our clinic?

What long-term expectations do you have for working with our clinic?

At this present time, how committed are you to addressing the underlying causes of your child's signs and symptoms that may relate to their lifestyle? (0=not committed and 10= completely committed) Please circle.

0 1 2 3 4 5 6 7 8 9 10

MEDICAL HISTORY

List all prescription medications your child is currently taking (with doses) _____

List all herbs/vitamins your child is currently taking (with doses) _____

List all **allergies** (food/environmental/drug) None Known _____

List and date all surgeries, hospitalizations and major accidents _____

Has your child ever experienced, been diagnosed or received treatment for the following? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> German Measles |
| <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Diptheria |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Sadness/Depression |
| <input type="checkbox"/> Sore throat/infection <i>frequency</i> _____ | <input type="checkbox"/> Ear Infections <i>frequency</i> _____ |
| # of Colds per year _____ | <input type="checkbox"/> EBV (mononucleosis) |
| <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> CMV (cytomegalovirus) |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Other _____ |

REVIEW OF SYMPTOMS (Please circle all that apply)

- | | | | | |
|-----------------|--------------------|-------------------|-----------------------|----------------------|
| Hives | Burning urine | Bloody urine | Eczema | Hair loss |
| Cries easily | Bleeding gums | Heart murmur | Nervous/anxiety | Dizzy spells |
| Nose bleeds | Vomiting spells | Sleep problems | Asthma | Frequent urination |
| Acne | Anemia | Night sweats | High fevers | Allergies/runny nose |
| Jaundice | Sensitive to light | Chronic rash | Stomach aches | Difficulty learning |
| Diarrhea | Hearing Loss | Easy bruising | Sore throats | Sadness |
| Flat feet | No appetite | Body/breath odor | Constipation/diarrhea | Spasms/cramps |
| Nightmares | Frequent colds | Bleeding tendency | Unusual fears | Behavior problems |
| Wheezing | Joint pain | Excessive fatigue | Paleness | Recurrent infections |
| Cough | Self-harm | Body image issues | Congenital illness | Bed wetting |
| Other(s)? _____ | Comments: _____ | | | |

Has your child had any of the following tests or procedures? (Please circle)

- | | |
|---|--|
| <input type="checkbox"/> Electroencephalogram (EEG) | <input type="checkbox"/> Blood transfusion |
| <input type="checkbox"/> Eye exam | <input type="checkbox"/> IVIG |
| <input type="checkbox"/> Psychological evaluation | <input type="checkbox"/> Allergy shots |
| <input type="checkbox"/> Speech/language testing | |

If so, what age and please explain circumstances: _____

Has your child had any of the following immunizations?

- | | | | |
|--------------------------------------|------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Polio | <input type="checkbox"/> Tetanus | <input type="checkbox"/> Measles/Mumps/Rubella | <input type="checkbox"/> Pertussis |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Influenza | <input type="checkbox"/> Hep B | <input type="checkbox"/> HPV |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hib | <input type="checkbox"/> Rotavirus | |

Any adverse reactions to any vaccines? Yes No If yes, please explain:

How was your child born? Vaginal Cesarean section

Was your child adopted and/or was there a surrogate? Yes No

If adopted or surrogate, are you aware of drug exposures including meth, heroin, cocaine, alcohol ? Yes No

Please explain: _____

Any complications with pregnancy or delivery? Premature Overdue Birth trauma Other?

Was your child breastfed? Yes No If so, how long? _____ Formula? _____ Milk type? _____

Has your child reached all age-appropriate milestones? (e.g. crawling, walking, talking, teething). Any delay in milestones? _____

When was the last time your child had a fever? What was the cause and temperature reading?

TOXIC EXPOSURES

Has your child ever lived in a smoking household or is around smoke? Yes No

Has there been exposures to lead, pesticides, mercury, drugs or other chemicals etc? Yes No

If yes, what and when? _____



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Has your child ever witnessed or been exposed to abuse (physical, emotional, sexual, other)? Yes No

FAMILY HISTORY

Please list all diseases and indicate biological familial relation if known (parents, grandparents, siblings only)

MOTHER’S HEALTH DURING PREGNANCY

Bleeding	Y N	Nausea	Y N
Hypertension	Y N	Diabetes	Y N
Physical/emotional trauma	Y N	Thyroid problems	Y N
Illnesses	Y N	If yes, what? _____	
Medications	Y N	If yes, what? _____	
Cigarettes, alcohol, drug consumption	Y N	If yes, what? _____	
Mother’s age at birth? _____			

Anything else you would like to share? _____

DIET

Does your child follow a specific diet? Yes No

If yes, please circle which one(s)

Vegetarian Vegan Paleolithic Anti-inflammatory Blood-type Atkins

Low-fat/low calorie Gluten-free Dairy-free Other _____

Please describe your child’s diet as accurately as possible:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

Are there certain foods that your child does not eat?

How is your child's appetite? Do they skip meals regularly or need multiple snacks between meals?

Are there certain foods that your child craves more than others? _____

What nutritional goals do you have for your child? _____

PHYSICAL ACTIVITY

Please explain your child's usual energy level? High, low, inconsistent? _____

At what part of the day is their energy level highest? _____

At what part of the day is their energy level lowest? _____

What does your child do for physical activity/exercise and how often do they do this? _____

Does your child participate in any sports? Which ones? _____

MENTAL/EMOTIONAL

Does your child seem more emotional than their siblings and /or other children? How so?

How does your child play with others? Do they join groups easily or prefer to play on their own?



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Does your child show a lack of interest in participating in activities or doing everyday things? If so, how often?

Does your child have any significant fears? Do they have night terrors? _____

Does your child have any issues with sleep? _____

LIFESTYLE

What types of daily or weekly lifestyle habits/activities do you feel support or strengthen your child's health?

What obstacles or challenges do you potentially anticipate that may undermine your child's health and following through on their care with us? _____

Who do you know that will sincerely support you and your child consistently with the lifestyle changes your child will be making to regain their health and vitality?

What does your child love doing; what brings them joy? _____

Patient Care Terms

Thank you for choosing Richmond Natural Medicine (“RMN”) for your healthcare needs. The following terms govern our relationship and by accepting care from RMN, you agree to the following:

APPOINTMENT & CANCELLATION POLICY

New patient visits are 120 to 180 minutes in duration and return visits are 60 minutes. If you are unable to make an appointment you will need to provide at least a 24-hour notice. This allows us to meet the needs of other patients who need an appointment. Due to this, follow-up appointments that are cancelled without providing a 24-hour notice will be charged a \$75 insufficient notice fee, new patient appointments that are cancelled without providing a 24-hour notice will be charged a \$100 insufficient notice fee.

RMN may, at its sole discretion, keep your credit card information on file through its credit card processor. You hereby give RMN permission to charge your credit card on file if you do not call and cancel your appointment within the timeframes below. Notification allows the practitioners to see another client who needs to be cared for that day.

COMMUNICATING WITH RICHMOND NATURAL MEDICINE AND YOUR PRACTITIONER

Email Policy

We recognize that many of our clients prefer to use email as a quick and easy way to communicate with a health care provider. We would like to offer this as a method to communicate for business and healthcare matters. You may contact your practitioner by email at the following address: patients@richmondnaturalmed.com. Here are some points we would like our clients to be aware of regarding email communications:

- 1) This type of communication is not always secure or confidential so to help ensure your privacy
 - a. Please do not send medical emails from your work email account
 - b. Please do not send information which you do not want shared; as email is never a guaranteed secure communication tool.
- 2) All medical email communications may be kept in your chart as part of your medical record.
- 3) Employees of Richmond Natural Medicine other than your provider, such as other health care providers and support staff, may have access to your e-mail address and e-mail content.
- 4) We will do our best to reply to emails within 48 hours, but there is always a chance that an email is not properly sent or received. If you do not hear from us within 2-3 days, please follow up with another email or by telephone.
- 5) In cases where an email response would not be appropriate or sufficient, you may be asked to schedule a phone or in-office appointment to ensure that your concerns get properly addressed.

Email Billing Policy

We recognize that for many clients, a quick medical question is sometimes easier to send through email. We would like to continue to welcome your questions this way, but due to an increasing volume of emails of this nature, and the amount of time practitioners are spending on email patient care, we have implemented an email billing policy. You may be billed for time spent responding to your email inquiries related to your health care depending on the complexity of and time spent responding to your inquiry. Time spent reading emails, researching medical questions and responding to requests will be billed at a rate of \$140.00 per hour.

Time will NOT be billed for:

1. Scheduling questions
2. Billing questions
3. Supplement refills
4. Clarification of your most recent treatment plan

If you would like to send us a health update that does not require a reply please type “No Reply Necessary” in the subject line of the email. This will ensure you will not be billed. We appreciate your consideration in following these policies. If you have any questions or concerns, please contact us at your convenience.

Phone Policy

At Richmond Natural Medicine, we have found that follow ups can be effectively managed over the phone, allowing us to take on many long distance patients.

We do ask, however, that you come in for your initial visit. The initial intake is a time for gathering pertinent information that will be useful throughout the course of treatment, therefore being there in person is an important factor in receiving the best care possible. Also, meeting you face to face allows us the opportunity to get to know you as a whole person, and allows you to get a feel of how we practice.

Appropriately timed follow ups are very important to your healing process, and we would love to be informed of significant health changes, or if you get acutely ill so that we can adjust your support plan as your health needs change. Phone consultations can be very useful in this way, as you do not have to come to the office for a last minute appointment or if you’re not feeling well enough to travel.

Phone Billing Policy

Your practitioner spends an equal amount of time and effort on your care over the phone as they do during in-office appointments, and therefore phone consultations will be billed at our normal follow up rate.

Your practitioner may call you for a quick check in after you begin a new remedy or make changes to your support plan. You will not be billed for these short (5-10 min) phone consultations, however if the call ends up requiring additional time or extensive decision making, you may be billed for the consultation or asked to schedule a follow up appointment at a later date.

Below are a few things we have found necessary to provide the most effective care for our clients, particularly those who are long distance or following up by phone:

1. You will need to have a local physician to perform examinations and manage prescription medications that are needed during the course of seeing your practitioner at Richmond Natural Medicine.
2. It is ideal if you have a close family member or friend who is willing and able to speak with us on occasion. This helps us gather observational details about your symptoms that may be missed in a phone consultation. It's also helpful if this person is willing and able to contact us on your behalf should a circumstance arise when you may be unable to do so.
3. We ask that you include us in all medical decision-making such as starting/stopping other therapies that may affect the progress of our therapies.

CONSENT TO TREATMENT

I am the parent or legal guardian of the child described above, and I am authorized to consent on behalf of this child. As used below in this Consent to Treatment, "I" means both the parent/legal guardian and the child.

I agree to abide by the guidelines of Richmond Natural Medicine, LLC ("RNM"). I understand that the Commonwealth of Virginia does not license or otherwise recognize naturopathic medical doctors. Therefore, neither Dr. Hollon, Dr. Nixdorf, Dr. Mielke Dr. Reckers, Dr. Bely nor any other naturopathic doctor participating in my care at RNM are permitted to diagnose or treat a given diagnosis of a disease/illness. The role of my naturopathic doctor is supportive, adjunctive and consultative in nature to assist in my health and well-being. I further understand that my naturopathic doctor may work with other physicians or health care providers. I further understand that if I need additional assistance or medical care, I will be referred to others within the community.

I hereby request and consent to the performance of naturopathic care and related procedures on me by the naturopathic doctor and/or any RNM personnel authorized by the naturopathic doctor. I further understand my naturopathic care may be performed by my RNM naturopathic doctor who may care for me or consult with me now or in the future at RNM. I have had an opportunity to discuss with my RNM naturopathic doctor and/or other RNM personnel the nature and purpose of naturopathic care and related procedures. I understand that results are not guaranteed and that neither RNM, nor my RNM Naturopathic Doctor, or any other RNM personnel warrant or guarantee any result or outcome.

In agreement with federal and state law, I agree to allow RNM to deliver the necessary care to me in order to provide continuity of care and treatment. RNM and/or my naturopathic doctor may obtain from any source and examine and use, or discuss and disclose, my medical records and information to RNM personnel and agents, other healthcare providers, medical records auditors, professional committees, care evaluators and governmental agencies. This information can include, but is not limited to: medical history, examinations, diagnoses, treatments any psychiatric, drug and alcohol abuse or genetic testing information, or HIV or AIDS information. This consent to release and obtain information is valid until revoked. I may revoke this consent in writing at any time, except with regard to disclosures that have already been made in reliance on such consent.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my naturopathic doctor. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at RNM. I understand RNM's fee, appointment, and cancellation policies as well.

Signature of individual or guardian

Date

RNM Representative

Date



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Payment Policy

Richmond Natural Medicine strives to ensure a clear understanding of your financial responsibility with respect to the services we provide. These policies apply to all procedures and products.

Payments: Payment for services rendered is due at the time of service. We accept cash, Visa, MasterCard, Discover and American Express. We also accept payment by check and debit cards. We hold a credit card number on file to secure your appointment and to secure necessary fees for breach of our cancellation policy. Richmond Natural Medicine will send clients accounts to collections for balances not paid after two failed attempts to collect on balances past due by 60 days or more. Payment plans are offered at management’s discretion. We reserve the right to require payment for services to be made at or before the time of service.

Outstanding balances: We may refuse to see patients who have large balances or are not making regular payments on their balance. If you have an unpaid balance at the end of a billing cycle, we may apply a \$5 late payment fee to your account. If you make a payment and it is insufficient to pay both the late payment charge and the principle amount due, we apply your payment to the late payment fee due and then we apply the remaining amount to the principal. In the event that your account is placed for collection, a collection fee will be added to your account, along with any attorney fees and/ or court costs that may be necessary for recovery of the outstanding balance. In the event of an “insufficient fund” check, there will be a \$25 insufficient funds charge added to the balance due.

Cancellations: We charge your credit card on file if you do not call and cancel your appointment within the time frames listed below. Notification allows the practitioners to see other clients who need to be cared for that day.

New Client and Follow-up appointments: Follow-up appointments that are cancelled without providing a 24-hour notice will be charged a \$75 insufficient notice fee, new patient appointments that are cancelled without providing a 24-hour notice will be charged a \$100 insufficient notice fee. Failure to show for an appointment will also result in a charge to your credit card.

Dependents: You are responsible for payment of services rendered to your dependents on your account.

I authorize Richmond Natural Medicine to keep my signature on file and to charge my credit card (held in our secure system) for:

1. Charges associated with appointments that are not cancelled within the timeframes listed above.
2. Charges associated with payment arrangements. Contact management to make payment arrangements.

Attestation Statement:

I have read, understand, and agree to the above Richmond Natural Medicine Payment Policy. I understand that charges are my responsibility. I acknowledge that these policies do not obligate Richmond Natural Medicine to extend credit.

Print Name of Patient (Or Parent / Guardian)

Signature of Patient (Or Parent / Guardian)

Date



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Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us.
This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: <input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> Discover <input type="checkbox"/> AMEX <input type="checkbox"/> Other
Cardholder Name (as shown on card):
Card Number:
Expiration Date (mm/yy):
Cardholder ZIP Code (from credit card billing address):

I, the undersigned patient of Richmond Natural Medicine, authorize Richmond Natural Medicine to charge my credit card above in accordance with the Richmond Natural Medicine Payment Policy. I understand that my information will be saved to file for future transactions on my account.

Print Name of Patient

Signature of Patient

Date

Notice of Privacy Practices

This notice, and the accompanying Practices Regarding Disclosure of Client Health Information, describe how health information about you may be used and disclosed, and how you can get access to your health information. Copies are given to all individuals receiving care. Please review this information carefully.

Understanding your health record: A record is made each time you come to Richmond Natural Medicine for a treatment or consultation. Your symptoms, the practitioner's assessment, and a plan of services are recorded. This record forms the basis for planning your care and treatment/consultation at future visits, and also serves as a means of communication among other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will assist you to ensure it is accurate and make informed decisions about who, what, when, where, and why others may be allowed access to your health information.

Understanding your health information rights: Your health record is the physical property of Richmond Natural Medicine, but the content is about you, and therefore belongs to you. You have the right to review or obtain a paper copy of your health record. You have the right to request restrictions, to authorize disclosure of the record to others, and be given an account of those disclosures. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information.

Our responsibility: Richmond Natural Medicine is required to maintain the privacy of your health information and to provide you with this notice of our privacy practices. We're required to follow the terms of this notice and to notify you if we are unable to grant your request to disclose or restrict disclosure of your health information to others. Richmond Natural Medicine reserves the right to change its practices and promises to make a good faith effort to notify you of any changes. Other than for the reasons described in this notice, Richmond Natural Medicine agrees not to use or disclose your health information without your consent.

Contact information:

Richmond Natural Medicine
9211 Forest Hill Ave
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Practices Regarding Disclosure of Client Health Information

Your health information will be routinely used for treatment/consultation, payment, and quality-monitoring, and your consent, or the opportunity to agree or object, is not required in these instances:

Treatment/Consultation: Information obtained by your practitioner at Richmond Natural Medicine will be entered in our record and used to plan the services provided you. Your health information may be shared with others involved in your care or providing consultation about your services. Your practitioner's own expectation and those of others involved in your care may also be recorded.

Payment: Your record will be used to receive payment for services rendered by Richmond Natural Medicine. A bill may be sent to either you or received directly upon services rendered.

Quality Monitoring: Richmond Natural Medicine will use your health information to assess the care you received and compare the outcome of your care to others. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services provided.

In addition, the following disclosures are required by law and do not require your consent:

Food and Drug Administration (FDA): This office is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements.

Public Health: This office is required by law to disclose health information to public health and/or legal authorities to avert a serious threat to health or safety, to report communicable disease, injury, or disability, or to comply with mandated reporting requirements for tracking of birth and morbidity.

Law Enforcement: As required under state or federal law, your health information will be disclosed to appropriate health oversight agencies, public health authorities, law enforcement officials, or attorneys: (1) In response to a valid subpoena; (2) In the event that a staff member of business associate of this office believes in good faith that one or more clients, workers, or the general public are endangered due to suspected unlawful conduct of a practitioner or violations of professional or clinical standards; (3) When a client is a suspected victim of abuse, neglect or domestic violence.

It is Richmond Natural Medicine's practice to consider the following as routine uses and disclosures for which specific authorization will not be requested. You have the right to request restrictions on these uses. Otherwise, Richmond Natural Medicine will request your authorization whenever disclosure of personal health information is necessary to parties other than those referenced here:

Business Associates: Some or all of your health information may be subject to disclosure through contracts for services to assist this office in providing health care. To protect your health information, we require these Business Associates to follow the same standards held by this office through terms detailed in a written agreement.



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Communications with Family: Using best judgment, a family member, close personal friend identified by you, personal representative, or other persons responsible for your care may be notified or given information about your care to assist them in enhancing your well-being or to confirm your whereabouts.

Consent

I consent to the use or disclosure of my protected health information by RNM for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of RNM. I understand that analysis, diagnosis or treatment of me by RNM may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. RNM is not required to agree to the restrictions that I may request. However, if RNM agrees to a restriction that I request, the restriction is binding on RNM.

I have the right to revoke this consent, in writing, at any time, except to the extent that RNM has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of RNM and understand that I have a right that Notice 's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of RNM. The Notice of Privacy Practices for RNM is also available at the front desk at 9211 Forest Hill Ave., Suite 204, Richmond VA. This Notice of Privacy Practices also describes my rights and duties of RNM with respect to my protected health information.

RNM reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of RNM and requesting a revised copy be sent in the mail or asking for one at the time of next appointment.

Signature of individual or guardian

Date

Print Name



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HIPAA Privacy Authorization Form

This form is required by the Health Insurance Portability and Accountability Act (HIPAA),

Section 45 C.F.R. Parts 160 and 164 Authorization

I, _____, authorize Richmond Natural Medicine (RNM) to use and disclose the protected health and demographic information to the individuals working within the establishment. Also, this authorization expires will expire one year from today's date: ____/____/____.

You have the following rights:

1. I have a right to refuse sign this authorization.
2. I have a right to receive a notice about my privacy policies.
3. I have a right to request and access my medical information.
4. I have a right to limit the uses and disclosure of my medical information.
5. This medical information will only be used by the person I authorize to receive this information health care and health consultation or other purpose I may authorize.
6. I understand that I have a right to withdraw this authorization, in writing, at any time during my care. I acknowledge that a withdrawal is not effective to the extent that any person or entity has already acted in reliance on my authorization.

I do not give anyone (family, caregiver, friends) access to my child's medical information related to their care

I do give the following individuals access to my child's medical information related to my care:

Name(s): _____

Expiration of access: _____

Signature of patient or personal representative

Printed name of patient or personal representative

Date ____/____/____