



## CONSENT TO TREAT, MEDICAL RECORDS, and PRIVACY

I, \_\_\_\_\_ the parent or legal guardian of the below named child(ren),

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Until we are notified in writing, Bowling Green Internal Medicine & Pediatric Associates will assume that a child's biological and/or legal parents are both legal guardians who have access to treatment options and medical information for that child.

I hereby authorize and consent to the examination/treatment of my child(ren) during the office and facility visits by the physician and clinical staff of Bowling Green Internal Medicine & Pediatric Associates. In addition, I give permission for the following person(s) to bring my child to Bowling Green Internal Medicine & Pediatric Associates in my absence and to act on my behalf in authorizing medical care and treatment.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Anyone not mentioned above who brings your child into the office for treatment must have a signed authorization from the child(ren)'s legal guardian.

### MEDICAL RECORDS and PRIVACY

At Bowling Green Internal Medicine & Pediatric Associates, we are committed to protecting the security and privacy of your child's personal information. Medical records are the property of Bowling Green Internal Medicine & Pediatric Associates. These records are kept in a secure location, and are accessed only for the purposes outlined by the Notice of Privacy Practices. Our revised Privacy Notice is available at [www.bgimp.com](http://www.bgimp.com), or you may request a copy from our office. Records may be released or shared with other healthcare professionals for the treatment of your child. Patients are entitled to one free copy of their medical records only after an authorization for release is signed. Additional copies may be made for a fee of \$1.00 per page, per KY House Bill 250.

- By signing below, I acknowledge that I have received Bowling Green Internal Medicine & Pediatric Associates Notice of Privacy Practices and consent to treat information. I understand that I can edit any of the terms below. I understand that BGIMP may call my home and place of employment for healthcare reasons, appointment reminders, to resolve billing issues, and may mail me information postcards to my home address. BGIMP may also mail bills to my mailing address.
- I understand that BGIMP may leave messages on my answering machine regarding appointments and limited lab information.
- I understand that BGIMP may use an email address or fax, provided by me to communicate appointment information, billing issues, immunization certificates, lab and test results, and other forms requested by the parent.
- I authorize BGIMP to email or fax immunization certificates and/or school forms, or to mail to my home address provided.
- I authorize BGIMP to discuss patient information with adults or other minors present during the visit regardless whether I am present.
- I understand that if I send a picture of myself or child(ren) BGIMP may display it within the office.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date