Nemours

01016

Patient Name: _____

Patient MR#: _____

AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION FOR TREATMENT, PAYMENT & HEALTH CARE OPERATIONS PURPOSES

I have the legal authority to authorize the examination and treatment of the above patient by Nemours health care providers and associates.* I understand that the examination and treatment may include the use of x-rays, laboratory tests (including routine HIV testing, when applicable), medications, and other diagnostic procedures and tests normally provided in a pediatric health care environment.

I understand that information, including recordings (photographs, video, electronic or audio media), may be collected, used, and disclosed only as necessary for:

- Treatment, payment, and healthcare operations purposes,
- Public health purposes, health oversight activities, accreditation, and other activities that promote wellness; and
- Other purposes as permitted by law.

If surgery, general anesthesia, blood products, provision of psychotropic medications or other extraordinary procedures or invasive procedures are required and not emergent in nature, then this will be explained to me by the physician or physician's designee. If this occurs, I will be asked to give additional written consent.

By agreeing to receive treatment at Nemours, I acknowledge that some of my child's/ward's medical care, services and treatment may be provided by physicians and other allied healthcare providers (such as, certified registered nurse anesthetists, physician assistants, advanced registered nurse practitioners or technicians) who are not employed by Nemours. I understand these providers are responsible for the medical care, services, and treatment that they deliver.

- I authorize the examination and treatment of my child/ward.
- I acknowledge:
  - If this is my first visit to Nemours that I have received a copy of the Notice of Privacy Practices, or
  - If this is not my first visit, I am aware the Notice of Privacy Practices can be obtained from our website www.nemours.org, or from any registration, greeter, or information location.
- I consent to the collection and sharing of information as indicated above and the uses and disclosures detailed in the Nemours Notice of Privacy Practices.
- I agree that Nemours will not be responsible for the medical care, services, and treatment delivered by physicians and allied healthcare providers not employed by Nemours.
- I understand this authorization applies and extends to subsequent visits and appointments at Nemours.

I certify that I have read and understand the above statements, that all of my questions have been answered to my satisfaction, and that I agree with each statement above.

_____	_____	_____	_____ AM
Patient/Person Legally Responsible	**Relationship to Patient**	**Date**	**Time PM**

***Nemours includes The Nemours Foundation, its operating divisions and sites, and its affiliates and subsidiaries.**