INFORMED CONSENT FOR TREATMENT AND PREVENTATIVE HEALTH CARE SERVICES

Please Read Carefully and Complete the Consent Form to Allow Your Child to Be Treated at the Gator HOPE Clinic

Patient Name_____ Date of Birth_____
Last First MI (MM/DD/YY)

Address_____City_____Zip_____

Parent/Guardian Name_____
Last First MI

Home Phone_____ Cell Phone_____

Work Phone_____ Email_____

I authorize the physician assistant to provide the necessary and/or advisable treatment for my child. I give my permission for medical evaluation, treatment and/or procedures for my child's medical condition within the capabilities of the facility and its personnel. I agree to completely disclose all known allergies, chronic illnesses, prior or current medications as well as any previous adverse drug reactions

Signed_____ **Date**_____

Allergies to medications_____ Current Medications_____

Past Medical History_____ School_____

Sex: *Male or Female* *Pharmacy Name and Location*_____

All services within the clinic are provided at no cost to the student with the exception of Sports Physicals. However we can better serve your overall needs if we know whether your child has health insurance

____Medicaid ____CHIP _____Private Health Ins ____None

The following information may be released for the benefit of my child:

__Clinically pertinent information __History and Physical __Immunizations __Other(specify)_____

Information may be disclosed to:

__Principal __School Counselor __School Nurse __Primary Physician __Other(specify)_____

Right to revoke authorization
Except to the extent that action already taken pursuant to this authorization, this consent will be in effect until revoked at any time by submitting a notice in writing to the Physician Assistant.

Re-disclosure
I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The facility, its employees, officers and physician assistant are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of patient or guardian who may request disclosure
I understand that I am not required to sign this authorization and my request for services above will not be denied if I do not sign this form below unless specified above under *other* information may be disclosed. I can inspect or copy the protected health information to be used or discussed. I authorize Gator HOPE Clinic to release the protected health information specified above:

Name_____ **Date**_____