Carteret Clinic for Adolescents and Children
312 Commerce Avenue • Morehead City, NC 28557
(252) 726-0511 • Fax: (252) 726-7441
www.carteretclinic.com

FOR OFFICE USE ONLY
rec'd by _____ / _____
completed by _____ / _____

AUTHORIZATIONS

Please read each authorization section carefully and sign at the bottom. If you have any questions, please ask for clarification. One must be signed for EACH patient. The following authorizations shall remain in effect until specifically revoked in writing.

Full Name of Patient (please print):_____Date of Birth _____

Certification of Authority to Consent
I certify that I am the Patient or the legal guardian of the Patient and, if the Patient is a minor, I certify that I am a parent of the minor Patient, or if living separate and apart or divorced, the custodial parent or authorized non-custodial parent of the minor Patient (collectively the "Patient or Legal Guardian") and that I have full authority to give legal and valid consent to the following for the Patient.

Consent for Treatment
I, being the parent or guardian of the Patient, who is a minor child, do hereby request and authorize the staff of Carteret Children's Clinic to perform any and all necessary services for the Patient, including but not limited to immunizations, labwork, and the administration of anesthetics which are deemed advisable by the provider, whether or not I am present at the actual appointment when the treatment is rendered. Any photos taken of the patient will be used for purposes of identification in the medical record. I understand that I have the right to refuse treatment without threat or termination of services except as outlined in the statute ***GS122C-57(d).*** Consent for treatment may be withdrawn at any time, in writing.

Release and Statement to Permit Payment of Private Insurance Benefits to Provider
The undersigned Patient or Legal Guardian hereby authorizes Carteret Children's Clinic, its agents and employees to release and disclose all or any part of the Patient's medical records to any entity which is, or may be, liable for all or part of the provider's charges for services rendered or items supplied to the Patient. The undersigned Patient or Legal Guardian authorizes the release and disclosure of any and all medical records to any other entity, including, but not limited to, referring physicians, hospitals, or other health care providers which may be of assistance, in the opinion of this office, in providing for the treatment of the Patient.

The undersigned Patient or Legal Guardian authorizes the release of records necessary to assist in the reimbursement of benefits to which the Patient or Legal Guardian may be entitled in connection with services rendered or items supplied to the Patient by Carteret Children's Clinic and authorizes this office and/or its employees to release, via fax, electronic or paper format, medical records which are needed in order to provide the Patient with the most appropriate medical care.

The undersigned Patient or Legal Guardian authorizes and requests that payment of any third-party or insurance company benefits be made to Carteret Children's Clinic for any services or items supplied to the Patient. The signatures furnished below shall suffice for all insurance forms on a continuing basis.

Consent for Protected Health Information Communication
The undersigned Patient or Legal Guardian hereby authorizes Carteret Children's Clinic to communicate with me by my preferred method as well as phone, voice mail, text, postal mail, email and fax regarding any items that assist the practice in carrying out TPO, such as appointment reminders, insurance and billing issues, and any issues pertaining to the Patient's clinical care, including laboratory results among others. For email, fax, and/or text communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email, fax and/or text communication as selected. **If I authorize only my preferred method of communication, I will notify the practice and complete the Communication Restriction form**. I have the right to request that Carteret Children's Clinic restrict how it uses or discloses the Patient's PHI to carry out TPO, however, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

Consent for Use and Disclosure of Protected Health Information
The undersigned Patient or Legal Guardian hereby authorizes Carteret Children's Clinic to use and disclose the Patient's protected health information (PHI) to carry out treatment, payment, and healthcare operations (TPO). I have been given a copy of and had the opportunity to review Carteret Children's Clinic Notice of Privacy Practices and Patient Rights and Responsibilities prior to signing this consent. I have been notified that release or disclosure of PHI may only occur with a valid consent unless it is an emergency or for other exceptions as detailed in the ***General Statues or in 45CFR 164.512 of HIPAA.***

Patient Rights
The undersigned Patient or Legal Guardian has been informed of their right to treatment, including access to medical care and habilitation, regardless of age, or degree of MH/DD/SA disability. I have been informed and given opportunity to review the Disability Rights NC and Patient Rights which are visibly posted in the patient waiting room.

Treatment plans for counseling services will be reviewed and provided in writing at the follow-up appointment by the counselor within 15 business days. Clinical summaries from a medical visit can be obtained via the patient portal within 3 business days.

(continued on other side)

SIGNATURE REQUIRED ON REVERSE

Revocation of Consent

The undersigned Patient or Legal Guardian has been informed of their right to revoke consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent. I may inspect the PHI to be disclosed as described in the document. Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law. I have the right to refuse to sign this authorization and that treatment of the patient will not be conditioned on signing.

I have read and understand the above certifications, authorizations, consents and rights. I have had a chance to ask any questions about these items and all my questions were answered to my satisfaction.

Signature of Parent or Legal Guardian: _____ **Date:** _____

Please print name in full: _____ **Relationship to patient:** _____