Alliance Pediatrics

CONSENT TO TREATMENT

_____ _____

Name of Patient *Patient's Date of Birth*

I am the parent or legal representative of the above-named minor child. I hereby consent to the medical and surgical examination, diagnosis and treatment of my child by Dr. Bruce Martin and the health care professionals at Alliance Pediatrics, as deemed necessary by them in their professional judgment. It is understood that the practice of medicine is not an exact science, and no guarantee can be given by anyone as to the results that will be attained from any diagnosis or treatment. The duration of this consent is indefinite and continues until revoked in writing.

Secure Messaging and Communication

The preferred method of communication regarding my child's medical condition is indicated below (check one):

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Mailed Letter ☐ Patient Portal ☐ Text

If the above method of communication is by phone, please check the appropriate box below:

☐ Leave a message with detailed information.
☐ Leave a message with a call back number only.
☐ Leave a detailed message if parent/authorized adult identifies themselves on voicemail greeting.

Please note that you are responsible for any charges incurred in receiving our communications. For example, if you provide a cell phone number as method of contact, then you are responsible for any charges imposed by your mobile carrier for receiving call or text messages from the clinic.

In order to support a fully electronic patient care experience Alliance Pediatrics has implemented use of its Patient Portal. The Patient Portal allows the parent or guardian to view visit information, medical history, lab results, request appointments, and have secure communication with our staff members.

☐ YES, I want Alliance Pediatrics to communicate my information with me through a secure system that is designed to keep my information safe. Please enter the email address you would like to use to receive these secure messages

_____@_____.com

☐ NO, I do not want Alliance Pediatrics to use electronic communication as a way to communicate information to me.

Alliance Pediatrics will not share your email address with anyone unauthorized to view your medical record.

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CONSENT TO TREATMENT

Sharing of Information with Family or Representative of Minors

The following individuals are authorized to view, discuss and/or obtain my child's health care information. The following individuals may also seek medical care and make decisions in relation to advice rendered by Dr. Bruce Martin and Alliance Pediatrics and/or its employees.

Name	Relationship	Medical Decisions	Emergency Contact	Phone
		☐	☐	
		☐	☐	
		☐	☐	

Vaccines and ImmTrac Texas Immunization Registry

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac"). Once in ImmTrac, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group –MC 1946, P.O. Box 149347, Austin, Texas 78714-9347.

☐ NO, I do NOT grant consent to include my child's immunization information in the Texas immunization registry.

I certify that I have read, understood and intend for Dr. Bruce Martin and Alliance Pediatrics to rely on this form.

_____ _____

Signature of Parent or Legal Representative *Date*

_____ _____

Printed Name of Parent or Legal Representative *Relationship to Patient*