PEDIATRIC ASSOCIATES OF WESTMORELAND

GREENSBURG · NORTH HUNTINGDON · MOUNT PLEASANT · CONNELLSVILLE

ACKNOWLEDGEMENT OF RECEIPT: PRIVACY PRACTICES/CONSENT TO TREAT

I, ____, the parent/legal guardian of the below named child:

Name of Child: ____ DOB: ______________ Sex: ___________

Patient Address: ____ City, State, Zip: ____________________________

hereby authorize and consent to the examination and/or treatment of my child during office and facility visits by the physicians and clinical staff of Pediatric Associates of Westmoreland. I acknowledge that I have received the Notice of Privacy Practices for Pediatric Associates of Westmoreland. In addition, I give permission for the following person(s) to bring my child to Pediatric Associates of Westmoreland in my absence and to act in my behalf and authorize medical care and treatment that may be involved in the healthcare of the patient. In the event of emergency or other illness, I understand that the physicians and staff of PAW will deliver any medical care deemed necessary, regardless of the accompanying adult. **For patients who reside with only one parent or guardian/foster care/non-biological caregivers, a current custody agreement must always be on file to ensure proper contacts.**

1. Name: ______________________________________ Relationship: ______________ Phone: _________________
2. Name: ______________________________________ Relationship: ______________ Phone: _________________
3. Name: ______________________________________ Relationship: ______________ Phone: _________________
4. Name: ______________________________________ Relationship: ______________ Phone: _________________

AUTHORIZATION FOR VACCINES

I, ____, give permission for the following named person(s) to consent to vaccines, or sign a vaccine refusal form, on my behalf, if I am not present for the appointment.
*** If parents/legal guardians are the only ones that are capable of making these decisions, please indicate below by marking '**none**' on the first line. ***

1. Name: ____ Relationship: _____________________
2. Name: ____ Relationship: _____________________
3. Name: ____ Relationship: _____________________
4. Name: ____ Relationship: _____________________

Parent/Guardian Signature: ____ Date: __________________

***** BELOW FOR OFFICE USE ONLY *****

I have offered the above-named patient/representative with the Pediatric Associates of Westmoreland Notice of Privacy Practices and they have: ☐ accepted ☐ refused delivery ☐ patient/representative was asked to sign form and refused.

PAW Representative Signature: _______________________________________ Date: ___________________________

Patient's Name: ____ Date of Birth: ____________________