Pediatric
ASSOCIATES OF YORK HOSPITAL

Physician Practices Consent Form

Patient Name: _____

Date of Birth: _____

I consent to diagnostic tests, treatments, or planned recurring treatments that the physician/practitioner deems necessary.

I understand that I have the right to be informed about the risks, benefits, and the alternatives to any care, treatment or procedure before I receive it.

I have the right to accept or refuse any medical or surgical care, treatment or procedure.

I authorize release of information needed to continue my care or to determine benefits for the services rendered.

I request that all payment of authorized benefits be made directly to York Hospital and all physicians or other professionals involved in my care.

I am aware that the York Hospital Privacy Notice has further information about how medical information may be used and disclosed. I have had the opportunity to receive and review this information and may request an updated copy at any time.

[ ] Permission to treat a minor: Many times parents find themselves unable to accompany their teen or child to appointments. Your signature will give us permission to treat should you be unable to accompany your child. Permission is valid to documented 1t has been canceled. Please note emancipated or married minors do not require parental consent.

_____ _____

Signature of Patient/Parent or Guardian Date

_____

Print Name

_____ _____

Witness Date