F. READ HOPKINS PEDIATRIC ASSOCIATES, INC.
COMPOUND CONSENT FORM

PATIENT(S) NAME:	DATE of BIRTH:

BIOLOGICAL MOTHER/LEGAL GUARDIAN NAME: _____

BIOLOGICAL FATHER/LEGAL GUARDIAN NAME: _____

F. Read Hopkins Pediatrics (FRHP) is dedicated to protecting the privacy of our patients. Except where required by law, FRHP will NOT authorize treatment, disclose, or discuss any information regarding your/your child's health or financial information with anyone other than the parent or legal guardian, unless otherwise listed below. **Please consider adding certain people such as step-parents, grandparents, relatives over the age of 18, babysitters, or other care providers that may need to seek treatment or advice in your absence.**

NAME	Relationship to Patient	Phone #	Permission for the following Circle all that apply
			• Bring in for appointment • Seek medical advice • Pick up prescripts/forms • Obtain lab results • Discuss financial/insurance info
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If you would like to have the ability to verbally request FRHP to fax school notes or immunization records to your child's school, please complete the section below:

SCHOOL NAME	PATIENT	FAX #	PERMISSION TO FAX THE FOLLOWING (Circle all that apply)
			SCHOOL NOTES IMMUNIZATION RECORDS
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			SCHOOL NOTES IMMUNIZATION RECORDS

F. Read Hopkins may post photos received from parent or legal guardian in office: yes no

I elect to receive communication such as appointment reminders, lab results, forms, etc. by: (circle)

VOICEMAIL TEXT EMAIL FAX

For email 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 and/or text communication as selected.

TELEPHONE COMMUNICATIONS:

You authorize us, our successors or assigns, to call, email or send you a text message to any number, email address you provide or at any number at which we reasonably believe we can contact you, including calls or texts to mobile, cellular, or similar devices, and including calls using automatic telephone dialing systems and/or prerecorded messages, for any lawful purpose, including but not limited to: (1) suspected fraud or identity theft; (2) obtaining information necessary or desirable; (3) your account transactions or servicing; and (4) collecting on your Account. Numbers you provide include numbers you give us and/or numbers from which you call us, our successors or assigns. You agree to pay any fee(s) or charge(s) that you may incur for incoming calls from us, our successors or assigns, and/or outgoing calls to us, our successors or assigns, to or from any such number, without reimbursement from us.

Signed_____ (Patient/Subscriber, or Parent of Minor) Date_____

CONSENT: I consent to allow the providers, nurses, and employees of F. Read Hopkins Pediatric Associates to perform all duties to diagnose, treat, and care for my/my child's health needs. I also understand that I have the right and responsibility to take part in making decisions regarding my/my child's care and plan for treatment.

DEEMED CONSENT: As a health care provider, we are required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

If one of our health care professionals, workers, or employees should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus ("HIV, the AIDS" virus) and for the presence of the Hepatitis B and Hepatitis C viruses. A physician or other health care provider will tell you and that person the result of the test and provide counseling, if necessary.

If you should be directly exposed to blood or body fluids of one of our health care professionals, workers, or employees in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus ("HIV, the AIDS" virus) and for the presence of the Hepatitis B and Hepatitis C viruses. A physician or other health care provider will tell you and that person the result of the test and provide counseling.

PATIENT RIGHTS:

I have the right to revoke this authorization at any time. I may inspect or obtain a copy of the protected health information to be disclosed as described in this document. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward. Information used or disclosed as a result of this authorization may be subject to redisclosure 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 my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by patient/parent/guardian, or at the time the minor child reaches 18 years of age.

_____ _____ _____

Signature of **BIOLOGICAL Mother**/Legal Guardian/Patient Relationship to Patient Date

_____

Print Name of **BIOLOGICAL Mother**/Legal Guardian/Patient

_____ _____ _____

Signature of **BIOLOGICAL Father** /Legal Guardian Relationship to Patient Date

_____

Print Name of **BIOLOGICAL Father** /Legal Guardian