Rainbow Pediatrics

413.241.6152

Patient Name: _____ DOB: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ acknowledge that I have received a copy of the Rainbow Pediatrics
(**Name of Patient**)

Notice of Privacy Practices. This notice describes how RAINBOW PEDIATRICS may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information and rights I may have regarding my protected health information.

_____

(Signature of Patient, or Parent or Personal Representative) (Date)

_____

(Relationship to Patient)

Acknowledgement of Receipt of Notice of Patient Bill of Rights

I, _____ acknowledge that I have received a copy of the Rainbow Pediatrics
(Name of Patient)

Notice of Bill of Rights.

This notice describes the patient's rights under the laws of the Commonwealth of Massachusetts.

_____

(Signature of Patient, or Parent or Personal Representative) (Date)

_____

(**Relationship to Patient)**

Consent for treatment of minor:

This is to authorize and consent to any necessary or routine medical treatment including comprehensive physical examination, injection(s), immunizations and /or diagnostic procedures, including X-ray and laboratory analysis. I understand that myself and those listed below will have authority to authorize treatment.

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

Anyone bringing the child for treatment and who is not listed above; must have dated signed letter of consent from me, or treatment could be refused. I understand that usual circumstances, efforts will be made to contact me prior to rendering treatment, but that medical treatment will not be withheld if I cannot be reached. This authorization shall remain in effect unless so designated that such consent for treatment of minor be canceled. I will notify Rainbow Pediatrics of any changes to this information, in the form of a signed and dated letter.

_____

Print Name Signature Date