

PARENTAL CONSENT FOR HEALTH CENTER SERVICES

I give permission for my child to be seen by a medical provider at Partnership Health Center as indicated above. I understand the Partnership Health Center will inform me of any emergency visits my child may have by phoning my contact telephone number. I give permission for Partnership Health Center to request and/or share my child's records as needed.
My signature indicates I have received a copy of the Notice of Privacy Practices.

X _____
Signature of Parent/Guardian

Date

HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information included with this form. My signature indicates my consent to release medical information as specified.

X _____
Signature of Parent/Guardian

Date