MY WHOLE CHILD Pediatrics Dr. Naveen Mehrotra
AN INTEGRATIVE APPROACH TO CHILD HEALTH

Consent for Treatment, Consent for the Use & Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that I have brought my child for management of his/her condition to this center of my will. I hereby authorize My Whole Child to perform the treatment and management services for my child. My Whole Child has explained the risks if any involved with the treatment procedure and I agree to the treatment.

I understand that as part of my child's healthcare, My Whole Child originates and maintains health records describing my child's health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many healthcare professionals who contribute to my care.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals

I understand that I have the right:

- To request restrictions as to how my health information may be used or disclosed to carry out
- To revoke this consent in writing, except to the extent that the organization is not required to agree to the restrictions requested.

By signing below, I hereby indicate that:

1) I have received & reviewed : ____ Consent for Treatment Form
   ____HIPAA Privacy Policy
   ____Assignment of Insurance Benefits Form
2) I understand the terms of these contract forms and
3) I agree to the terms of this contract

Patient's Name (Please Print) _____

Parent/ Guardian (Please Print) _____

Signature_____

Date_____**Date of Birth of Child**_____