

Robert H. Strashun, M.D. Patient Consent Form

With this consent, the Office of Robert H. Strashun, M.D. may:

- Call my home or other location that I specify, and leave a message regarding appointment reminders, insurance items, and any calls pertaining to my child's clinical care, including lab and x-ray results.
- Use and/or disclose certain protected health information (PHI) about my child for schools, camps or sports, on a form that I submit for completion.
- Provide immunization records or forms by fax to my child's school.

Please indicate how you prefer to be contacted regarding the following (**circle one for each item**):

Medical Issues:	Home phone	Cell Phone
Appointment Reminders:	Home phone	Cell Phone
Appointment Recalls:	Home phone	Cell Phone

Optional:

I give permission to the office of Robert H. Strashun, M.D. to treat and/or immunize my child in the event that I am unable to accompany him or her to the office. I understand that in all situations the doctor prefers to have a parent present to obtain a medical history and to give permission for treatment or vaccinations. By sending my child with a caregiver or by sending my adolescent child alone, I am giving advance consent to any medical procedure the physician deems necessary.

Persons other than a parent or legal guardian authorized to accompany my child to an appointment include:

Name _____ Relationship: _____ Phone # _____

Name _____ Relationship: _____ Phone # _____

Name _____ Relationship: _____ Phone # _____

Child's Name(s): _____ DOB: _____

Child's Name(s): _____ DOB: _____

Child's Name(s): _____ DOB: _____

Signature of Parent/Guardian: _____

Print Parent/Guardian Name: _____ Date: _____