First Choice Health Centers
For All Your Health Care Needs

94 Connecticut Boulevard, East Hartford, Connecticut 06108
Phone: (860) 528-1359 Fax: (860) 528-5180

CONSENT TO TREAT A MINOR

Patient Name _____ DOB _____ Chart Number _____

Patient resides with Mother _____ Father _____ Other _____

Parent 1 – First & Last Name _____ Parent 2 – First & Last Name _____

A child's parent or legal guardian must accompany their child for **new patient and well child visits**. A parent or legal guardian may choose up to two other adults (age 18 or older) to accompany their child to *sick and follow up visits* ***except*** if the child's doctor requires a parent or legal guardian to accompany the child.

Please provide us with the name and relationship of the adult you wish to accompany your child. The adult you choose must provide the Center with a Government-issued, current photo identification prior to or at the first visit to the Center with the patient.

First Name	Last Name	Relationship to Patient

NOTE: The designation of another adult to accompany the child does *not* authorize that person to make health care decisions for the child. The parent or legal guardian is still responsible for making health care decisions for the child.

I, the undersigned give permission to First Choice Health Centers, Inc. permission to treat: _____ (Name and Date of Birth), for Primary Care Purposes on this current date.

I authorize my child's Provider to use and disclose my child's medical information including, if applicable, dental, protected drug and/or alcohol abuse, and confidential HIV-related information ("Protected Health Information") for treatment, payment and health care operations purposes. My consent includes the release of such information to process claims to my child's insurance company. I authorize direct payment from my child's insurance company to Provider. If at any time I decide I want to file my own claims, I understand that payment in full will be required at the time of service. I also understand that I will be financially responsible for all charges incurred. The Provider's Notice of Privacy Practices further explains how Provider may use and disclose my child's Protected Health Information. I have received a copy of the Notice of Privacy Practices today or at an earlier date.

I, the undersigned attest that I am the legal guardian of the above mentioned minor.

_____ _____
Signature of Legal Guardian Date

_____ _____
Signature of Witness Date

ANY INFORMATION RELEASED BY PROVIDER TO AUTHORIZED PERSONS IS SUBJECT TO THE FOLLOWING NOTICES:

Drug and Alcohol Abuse Information:

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

HIV-Related Information:

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In the event that information released constitutes confidential HIV-related information protected under Connecticut law:

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.