Peds & Parents Family Care, LLC

124 Andrews Way, Suite B St. Marys, Georgia 31558
Tel: (912)729-7007 FAX: (912)729-3627
Visit us online: www.pedsnparentsfamilycare.com

Pediatric Patient Application & Registration

We ask that you take this time to complete the "Patient Application & Registration" questionnaire in full. Our providers rely on your thorough and honest answers to determine if they will be able to provide beneficial care to you.

Patient Information

First Name	Middle Name	Last Name
Date of Birth (mm/dd/yyyy)	Social Security Number	Gender
		☐ Male ☐ Female

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer Not to Disclose

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Preferred Language: ☐ English ☐ Spanish ☐ Other:

Email Address:

Mailing Address	City	State	Zip

Primary Phone	Secondary Phone	Additional Phone

Emergency Contact's Name	Relationship to Patient	Emergency Contact's Phone

Employment Information

Employer	Occupation	Employer Phone

Guarantor Information (Responsible Party-If Other Than Patient)

Guarantor Name:

Patient's Relationship to Guarantor: ☐ Dependent ☐ Self ☐ Spouse ☐ Other

Guarantor Date of Birth (mm/dd/yyyy)	Guarantor Social Security Number

Guarantor Address	City	State	Zip

Guarantor Primary Phone:

For Completion by the Healthcare Provider: *(Office Use Only)*

I have reviewed the registration information and medical history submitted for this prospective patient. This patient has (☐Been Approved / ☐Not Been Approved) to receive care from Peds & Parents Family Care, LLC.

_____

Provider Signature or Initials

Please be advised that we are a vaccinating clinic. If you refuse vaccinations for your child, you will be asked to find another primary care office. Please see our vaccine policy for more information.

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Insurance Information

Insurance Company	Claims Address		
Insurance Phone Number	Policy Number/ID #	Group Number	
Patient's Relationship to Policyholder ☐ Dependent ☐ Self ☐ Spouse ☐ Other			
Policyholder's Name	Policyholder Date of Birth	Policyholder Social Security #	
Does your insurance require referrals? ☐ Yes ☐ No ☐ Not sure			

Preferred Pharmacy (It is important that you supply us with this information as we use ePrescribe)

Preferred Pharmacy Name	Preferred Pharmacy Phone Number		
Pharmacy Address	City	State	Zip

Additional Questions

Are you a former Peds & Parents patient? ☐ Yes ☐ No

If so, approximately how long ago do you believe you were last seen?

How did you hear about Peds & Parents? If you were referred to us, please indicate who referred you.

Reason for Requested Appointment:

Certification of Completion

I have supplied the above information on behalf of myself or my dependent and attest that it is true and complete to the best of my knowledge.

_____ _____

Signature Date

Relationship to Patient: _____

Additional Registration Information for Pediatric Patient: _____

This document contains confidential information to be released only with your written authorization.

Parent or Guardian Information

First Name	Middle Name	Last Name	
Date of Birth (mm/dd/yyyy)	Social Security Number	Relationship to Patient:	
		☐ Mother ☐ Father ☐ Other:	
Email Address:			
Mailing Address	City	State	Zip
Primary Phone	Secondary Phone	Additional Phone	

First Name	Middle Name	Last Name	
Date of Birth (mm/dd/yyyy)	Social Security Number	Relationship to Patient:	
		☐ Mother ☐ Father ☐ Other:	
Email Address:			
Mailing Address	City	State	Zip
Primary Phone	Secondary Phone	Additional Phone	

Marital Status of Parents: ☐ Married ☐ Divorced ☐ Separated ☐ Never Married

Adults permitted to bring child for care or receive medical information about the child:

Name:	Relationship to child:
Name:	Relationship to child:
Name:	Relationship to child:
Name:	Relationship to child:

Home & Social History

Who lives in the home with your child?

Name:	Relationship to child:
Name:	Relationship to child:
Name:	Relationship to child:
Name:	Relationship to child:
Name:	Relationship to child:

Does anyone smoke around your child? ☐ Yes ☐ No If yes, who?

Are there any guns in the home? ☐ Yes ☐ No If yes, are they locked up? ☐ Yes ☐ No

I have supplied the Registration Information for this Pediatric Patient as well as the Medical History for this Pediatric Patient on behalf of my dependent and attest that it is true and complete to the best of my knowledge.

_____ _____

Signature Date

Relationship to Patient: _____

Medical History for Pediatric Patient:_____

This document contains confidential information to be released only with your written authorization.

PARENTS AND SIBLINGS			
Mother	☐ Living	☐ Deceased	Age at death:
Father	☐ Living	☐ Deceased	Age at death:
Number of Brother(s)	Current ages if applicable:		Medical problems, if any:
Number of Sister(s)	Current ages if applicable:		Medical problems, if any:

FAMILY HISTORY	
Include parents, grandparents, aunts/uncles, and siblings.	
	Family Member(s)
☐	Coronary Artery Disease
☐	Hypertension
☐	Hyperlipidemia
☐	Stroke
☐	Diabetes
☐	Kidney Disease
☐	Breast Cancer
☐	Colon Cancer
☐	Prostate Cancer
☐	Mental Illness
☐	Substance/Alcohol Abuse
☐	Other:
☐	Other:

BIRTH HISTORY	
Pregnancy Complications	
☐	Pre-eclampsia
☐	Maternal diabetes
☐	Premature delivery
☐	Other:
☐	Child was delivered at term (40 wks)
☐	Child was born early at _____weeks
Complications after birth until about 2 weeks of age:	
Birth Weight: _____ pounds _____ ounces	

ACTIVITY LEVEL, NUTRITION, & SCHOOL
Number of hours/day spent on each of the following:
____ Doing homework
____ Watching TV
____ Playing Video Games
____ Computer/ Internet
____ Sleeping
____ Playing Sports, please list:
Do you think that your child eats healthy? ☐ Yes ☐ No
If not, please list your concerns:
School: ☐ Public ☐ Private
School Performance:
☐ Above Average ☐ Average ☐ Below Average
Discipline problems at school? ☐ Yes ☐ No
Please elaborate on any school concerns:

HOSPITALIZATIONS	
Hospitalization	**Date**

SURGERIES	
Surgery	**Date**

MEDICATIONS		
Please list all over-the-counter, prescription, and natural medications including supplements.		
Medication	**Dosage**	**Times Per Day**

IMMUNIZATIONS		
☐ Up to Date	☐	Not Immunized
☐ Not Up to Date	☐	Not Sure
State of Vaccination(s): ☐ Georgia ☐ Other:		
Medical Offices that administered your child's vaccines:		
Name of Office	**Telephone**	**City, State**

Medical History for Pediatric Patient:_____

This document contains confidential information to be released only with your written authorization.

Please indicate if your child currently has or has ever had any of the following:				(DK = don't know)
Chicken pox	☐ Yes	☐ No	☐ DK	When/Explain:
Frequent ear infections	☐ Yes	☐ No	☐ DK	When/Explain:
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	When/Explain:
Nasal allergies	☐ Yes	☐ No	☐ DK	When/Explain:
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	When/Explain:
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	When/Explain:
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	When/Explain:
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	When/Explain:
Blood transfusion	☐ Yes	☐ No	☐ DK	When/Explain:
HIV	☐ Yes	☐ No	☐ DK	When/Explain:
Organ transplant	☐ Yes	☐ No	☐ DK	When/Explain:
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	When/Explain:
Chemotherapy	☐ Yes	☐ No	☐ DK	When/Explain:
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	When/Explain:
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	When/Explain:
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	When/Explain:
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	When/Explain:
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	When/Explain:
Cancer	☐ Yes	☐ No	☐ DK	When/Explain:
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	When/Explain:
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	When/Explain:
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	When/Explain:
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	When/Explain:
Frequent headaches	☐ Yes	☐ No	☐ DK	When/Explain:
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	When/Explain:
Obesity	☐ Yes	☐ No	☐ DK	When/Explain:
Diabetes	☐ Yes	☐ No	☐ DK	When/Explain:
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	When/Explain:
High blood pressure	☐ Yes	☐ No	☐ DK	When/Explain:
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	When/Explain:
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	When/Explain:
Tobacco use	☐ Yes	☐ No	☐ DK	When/Explain:
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	When/Explain:
Developmental delay	☐ Yes	☐ No	☐ DK	When/Explain:
Dental decay	☐ Yes	☐ No	☐ DK	When/Explain:
History of family violence	☐ Yes	☐ No	☐ DK	When/Explain:
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	When/Explain:
(For females) Pregnancy	☐ Yes	☐ No	☐ DK	When/Explain:
(For females) Problems with periods	☐ Yes	☐ No	☐ DK	When/Explain:
(For females) Has had first period	☐ Yes	☐ No	☐ DK	When/Explain:
Any other significant problems	☐ Yes	☐ No	☐ DK	When/Explain:

Allergy Questionnaire - Intake Questions

To Be Filled Out by Patient

Patient Name _____ Birthdate _____

Reviewed by _____ Date _____

1. Does your child experience any of these symptoms more than twice per year: Cough, cold, congestion, difficulty breathing, headaches, wheezing, runny nose, sore throat, itchy/irritated eyes, sinus pain, ear pain, unexplained fatigue, skin irritation, snoring? ❑ Yes ❑ No
2. Has he/she ever been diagnosed with asthma or bronchitis? ❑ Yes ❑ No
3. Does he/she experience symptoms of allergies? ❑ Yes ❑ No

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Vaccine Policy Statement

Vaccinating children and young adults may be the most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedule given are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

We advise you to vaccinate your child because we truly care about you and your family. No child should have to suffer from a preventable illness. We seek to educate you on the facts regarding vaccinations so you will understand the importance of choosing to vaccinate.

A thorough review of available literature, evidence, and current studies indicates that vaccines do not cause autism or other developmental disabilities. Thimerosal, a preservative that has been in vaccines for decades and remains in some vaccines, does not cause autism or other developmental disabilities.

We believe in the effectiveness of vaccines to prevent serious illness and to save lives.

We believe in the safety of vaccines.

We believe that children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and Prevention and the American Academy of Pediatrics.

Having stated these beliefs, we recognize that there has always been and will always be controversy surrounding vaccination. Benjamin Franklin, persuaded by his brother, was opposed to smallpox vaccine until scientific data convinced him otherwise. Tragically, he had delayed inoculating his son Franky, who contracted smallpox and died at the age of 4, leaving Ben with a lifetime of guilt and remorse. Quoting Mr. Franklin's autobiography:

> *"In 1736, I lost one of my sons, a fine boy of four years old, by the smallpox...I long regretted bitterly, and still regret that I had not given it to him by inoculation. This I mention for the sake of parents who omit that operation, on the supposition that they should never forgive themselves if a child died under it, my example showing that the regret may be the same either way, and that, therefore, the safer should be chosen."*

The vaccine campaign is a victim of its own success. It is because vaccines are so effective at preventing illness that we are even discussing whether or not they should be given. Because of vaccines, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis, or even chickenpox. You have not known a friend or family member whose child died of one of these diseases. Such success can make us complacent and lazy about vaccinating. Such an attitude, if it becomes widespread, can only lead to tragic results.

By not vaccinating your child, you are relying on herd immunity which takes advantage of thousands of others who do vaccinate their children. In other words, because other children may be vaccinated, the likelihood of your child contracting one of these diseases decreases. That proves to be a very risky decision which may result in deadly consequences for your child.

Over the past several years, some parents in Europe chose not to vaccinate their children with the MMR vaccine after publication of an unfounded suspicion (later retracted) that the vaccine caused autism. As a result of under-immunization, there have been small outbreaks of measles and several deaths from complications of measles in Europe over the past several years.*

We recognize that the choice to vaccinate may be a very emotional decision for some parents. We will do everything we can to educate you that vaccinating according to the schedule is the best thing you can do for your child. However, **should you have doubts, please discuss these with your health care provider in advance of your visit. Please be advised, however, that delaying or "breaking up the vaccines" to give one or two at a time over two or more visits goes against expert recommendations, and can put your child at risk for serious illness (or even death) and goes against our medical advice as providers at Peds & Parents Family Care, LLC. *We do not "break up vaccines" for financial and moral reasons.***

Additional visits will require additional co-pays on your part. Furthermore, please realize that you will be required to sign a "Refusal to Vaccinate" acknowledgement in the event of lengthy
delays.

If you should absolutely refuse to vaccinate your child despite all our efforts, *we will ask you to find another health care provider who shares your views.* We do not keep a list of such providers, nor would we recommend any such physician. Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and disability, and even death.

As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. Thank you for reading this policy. We encourage you to review the sources on the back of this page to further educate yourself on the safety and effectiveness of vaccines. If you have any questions, a member of our team would be happy to discuss any questions or concerns you may have.

DR. MARY LEE CARTER, MD, MEDICAL DIRECTOR

ROBERT DAVENPORT-RAY, APRN, CEO

Koleva, G. (2012, July 7). What Recent Measles and Rubella Outbreaks in Europe Can Teach the U.S.. Forbes. Retrieved August 5, 2013, from http://www.forbes.com/sites/gerganakoleva/2012/07/02/what-recent-measles-and-rubella-outbreaks-in-europe-can-teach-the-u-s/

Peds & Parents Family Care, LLC

Boards Certified Physicians, PA-Cs & Nurse Practitioners

124-B Andrews Way

Saint Marys, Georgia 31558

Vaccine Policy Agreement

Immunizations - Vaccinating children and young adults may be the most important health-promoting intervention that is performed by health care providers. Because vaccines are effective at preventing serious illnesses and saving lives, it is our policy to vaccinate and immunize all children that are cared for at our facility. Due to the serious health hazards of not vaccinating children, if you (parent/guardian) at any time choose to not vaccinate your child, we will request that you seek care from another clinic.

****

I have read and understand Peds & Parents Family Care's policy regarding vaccines for my child and agree to comply. If at any time I refuse to have my child vaccinated for **mandatory** vaccines, I understand this can result in dismissal of care from the practice.

_____ _____

Parent/Guardian Printed Name Date

_____ _____

Parent/Guardian Signature Date

_____

Child's Name

(912) 729-7007

ppfc@pedsnparents.com

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Patient Policy Acknowledgement, Authorization, & Release

I have received the Patient Policy Overview for Peds & Parents Family Care, LLC. These policies include new patient, office hours, scheduled appointments, cancelled and missed appointments, prescription refills, phone calls and messages, on call staff, immunizations, requests for medical records, request for document completion, and payment policies. I understand the policies as described and understand my responsibilities as a patient and/or guarantor. I agree to abide by all of these policies and understand that my failure to do so may result in myself and/or my family being discharged as patients from Peds & Parents Family Care, LLC.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of me or my dependents.

I understand information in my patient chart is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my medical record to a physician, hospital, or other medical professional involved in providing me with emergency treatment and/or medical care.

I authorize Peds & Parents, LLC, to release any pertinent information, including the diagnosis and records of treatment/examination rendered during the period of care, to third party payers and/or other healthcare practitioners involved in the care. I authorize and request my insurance company to pay directly to the healthcare providers the benefit otherwise payable to me.

I have listed below all family members that I and/or the responsible party may bring to Peds & Parents Family Care for healthcare services.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

*Signature of Patient or Patient's Legal Guardian Date

*Form must be signed by a legal guardian for all minors.

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Patient Consent for Use & Disclosure of Protected Health Information

I hereby give my consent for Peds & Parents Family Care to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by Peds & Parents Family Care describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Peds & Parents Family Care reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Business Manager at Peds & Parents Family Care, 124 Andrews Way, Suite B, Kingsland, GA 31548.

With this consent, Peds & Parents Family Care may mail to my home or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Peds & Parents Family Care may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Peds & Parents Family Care restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Peds & Parents Family Care to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Peds & Parents Family Care may decline to provide treatment to me.

Signature of Patient or Legal Guardian	Date
Printed name of Patient	Printed Name of Legal Guardian, If Applicable

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Authorization for Release of Medical Information From Previous Healthcare Provider/Specialist

I hereby request and authorize the following health care providers:

Previous Healthcare Provider's Name _____ Office Name _____

Office Location _____ Office Phone _____

Office Fax _____ Type of Specialty (if applicable) _____

to release the following type(s) of information:

_____ Shot Record

_____ Complete Medical Record

from the medical records of myself, my child or children:

Name:_____ DOB:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

for the purpose of continuity of care. Please release these records to:

Peds & Parents Family Care, LLC
124 Andrews Way, Suite B
St. Marys, GA 31558
PH: (912) 729-7007
Fax: (912) 729-3627

All information I hereby authorize to be obtained will be held strictly confidential and cannot be released without my written consent. I understand that this authorization will remain in effect until I withdraw this consent by providing written notification to Peds & Parents Family Care, LLC, at the above address.

Signature of Patient or Patient's Legal Guardian _____ Date _____

Printed Name of Patient or Patient's Legal Guardian _____

Signature of Witness _____ Date _____

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About Our Patient Portal

Azalea Health Web-based Patient Portal lets patients and doctors communicate easily, safely and securely over the internet. Patients are emailed a link to setup secure passwords that allow them to log into their physician's system to see their own private set of documents including labs, diagnostics, vitals, visit information, statements and messages.

Patient portals use leading edge technology to promote healthcare and make it easier to perform preventive care. It is an exceptional tool to communicate with patients. The patient portal gives patients 24 x 7 access to their medical information from the comfort and privacy of their own home or office.

The patient portal allows patients to view medication history, lab results, diagnostic results and appointment information in a timely manner. Patients can also complete health assessments and examine their statements to see their balance and much more.

Using Azalea Health Patient Portal, providers have faster and timelier interaction with the patient, and no wasted time playing "phone tag." Instant Medical History provides an additional level of secure communication between patient and provider, allowing providers to be informed and pro-active at the time of the encounter.

Patient Portal Use Agreement

Peds and Parents Family Care, LLC provides this site in partnership with Azalea Health Innovations for the exclusive use of its patients. The patient portal is designed to enhance patient-physician communications and improve patient care and satisfaction.

******DO NOT USE THE PORTAL TO COMMUNICATE IN AN EMERGENCY******

We strive to keep all of the information in your records correct and complete. If you identify any discrepancy on your record, you agree to notify us immediately. Additionally, by using the patient portal, the user agrees to provide factual and correct information.

The patient portal provides the following services:

- Access to view and print your Personal Health Record (PHR)

- Review of the patient's visit summary, medication list, treatment history

- View lab results that have been sent to you

- Update your demographic information

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The patient portal is not designed to provide internet based diagnostic services. Also the following limitations apply:

- No internet based triage or treatment requests can be made. Diagnosis can only be made and treatment rendered after the patient schedules and sees the provider.

- Any emergent conditions should be seen by urgent care appointment, the Emergency Department of the local hospital, or by calling 911.

- You cannot request re-fill medications.

The patient portal is provided as a courtesy to our valued patients. If abuse or negligent usage is suspected, Peds and Parents Family Care, LLC reserves the right at our own discretion to terminate patient portal offering, suspend user access, or modify services offered through the patient portal.

Protecting Your Private Health Information and Risks

Peds and Parents Family Care, LLC understands the importance of privacy in regards to your health care and will continue to strive to make all information as confidential as possible. Your private information, including email addresses, will never be sold or shared, without your written consent.

The patient portal is provided in partnership with, Azalea Health Innovations, our software vendor. The data is provided through a secure web portal which uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password to the portal site. Because the connection channel between your computer and the website uses Secure Sockets Layer (SSL) technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security.

You need to keep unauthorized individuals from learning your password. If you think someone has learned your password you should promptly go to the website and change it. Please make sure to provide us with your correct email address and you must inform us if it ever changes. Do not print your information on paper and leave it lying around or carry it into public places where it can be viewed or taken by others. Do not store the information on your personal or work related electronic devices. If you print, copy, save your information in any format that is not secure, it is your responsibility to protect that information and not that of Peds and Parents Family Care, LLC, Azalea Health Innovations and/or our employees and business partners.

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Please read our HIPAA policy for information on how personal health information (PHI) is used at Peds and Parents Family Care, LLC. All new and established patients have signed a HIPAA agreement form and have been given a copy of our HIPAA policy. If you do not recall having signed a HIPAA agreement form or need to reacquaint yourself with our HIPAA policy, a print or electronic copy in PDF format will be provided to you for your review.

Acknowledgement

I acknowledge that I have read and fully understand this consent form. I have been given the risks and benefits of patient portal use and agree that I understand the risks associated with online communications between my physician and patient, and consent to the conditions outlined herein. I acknowledge that using the patient portal is entirely voluntary and will not impact the quality of care I receive from Peds and Parents Family Care, LLC should I decide against using the patient portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that my physician may impose for online communications. I have asked questions related to this consent agreement and I understand the information provided in the answers.

_____
Print Name

_____
Primary Email Address

_____ _____
Signature Date:

List the names of all patients of Peds and Parents Family Care that the above signed has been granted legal access to their medical records. (ie: spouse, dependents, and/or minors).

_____

_____

_____

_____

_____

_____

_____

_____