Mississippi Children's HEART CLINIC

CONSENT FOR TREATMENT

PATIENT INFORMATION

Patient Name: _____ Date of Birth: ____ / ____ / _____ Medical Record #: _____

I hereby authorize the physicians, nurses, and other healthcare providers at Mississippi Children's Heart Clinic to perform any examinations, diagnostic tests, and medical or surgical treatments that are deemed advisable for my child.

I understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of treatments or examinations in this clinic. I acknowledge that I have been given the opportunity to ask questions and that my questions have been answered to my satisfaction.

I consent to the administration of medications, vaccines, and other treatments as may be necessary. I also consent to the use and disclosure of my child's Protected Health Information for treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

I understand that I am financially responsible for all charges whether or not paid by insurance. I agree to cooperate fully with the clinic's policies and procedures.

This consent will remain in effect until revoked in writing. A photocopy of this consent shall be considered as valid as the original.

Parent / Legal Guardian Signature: _____ Date: ____ / ____ / _____

Parent / Legal Guardian Name (Print): _____

Relationship to Patient: _____

Witness Signature: _____ Date: ____ / ____ / _____

Witness Name (Print): _____