CHILDREN'S MEDICAL OFFICE
of North Andover, P.C.

Consent to Treatment and Use of Health Information

Consent for Medical Treatment

I allow the healthcare providers of *Children's Medical Office of North Andover, P.C.* to give the patient named below medical care, including medical examinations, diagnostic testing or procedures, administration of medications, treatment, and other medical services as determined by the provider. I understand that absent emergency circumstances, major therapeutic and diagnostic procedures will not be performed unless I have had the opportunity to discuss such procedures and the risks associated therewith to my satisfaction and I have consented to such procedure. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantee has been made to me promising any specific result or outcome.

Release of Information for Payment and Assignment of Benefits

I agree that *Children's Medical Office of North Andover, P.C.* can share the patient's health information with the patient's health plan or other payment source in order to receive payment for services rendered. I hereby assign to *Children's Medical Office of North Andover, P.C.* the right to health insurance benefits otherwise payable to me or the patient on account of the care provided, and I authorize such medical insurance benefits to be paid directly to *Children's Medical Office of North Andover, P.C.*. I agree to cooperate and provide information as needed to establish my eligibility for such benefits. A copy of this assignment and authorization may be used in place of the original.

Sharing Information Electronically

Children's Medical Office of North Andover, P.C. may share information electronically with other healthcare providers involved in the patient's care. Information may be shared using platforms such as the Massachusetts Health Information Highway (Mass HIway), Massachusetts Immunization Information System (MIIS), EpicCare Link, Care Everywhere, and others. I agree that *Children's Medical Office of North Andover, P.C.* can use these platforms to share the patient's medical information. I have been provided with a copy of the *Children's Medical Office of North Andover, P.C.* Notice of Privacy Practices that describes other uses and disclosures of health information.

Acknowledgment

This approval will remain in effect until the patient leaves *Children's Medical Office of North Andover, P.C.*

_____	_____
Patient's Name	Patient's Date of Birth
_____	_____
Parent/Legal Guardian's Name (if applicable)	Relationship to Patient
_____	_____
Signature of Parent/Legal Guardian/Self (if 18+)	Date