Desert Willow Pediatrics
Joy Peskin M.D., F.A.A.P

Patient Consent Form

I give permission to the office of Desert Willow Pediatrics/ Joy Peskin, 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 family member, caregiver, or by sending my adolescent child alone, I am giving advance consent to any medical treatments or procedures deemed necessary by the provider.

With this consent, the office of Desert Willow Pediatrics/ Joy Peskin, M.D. may:

- Treat my child according to AAP standards and the realm of medical necessity deemed appropriate.
- Call my home or other location that I indicated and leave a message regarding appointment reminders, insurance items, and any calls pertaining to my child's care.
- 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 or email to my child's school or any entity needing them.

Patients (18+)

The confidentiality of our patients' medical information is extremely important to us. We understand at times there may be circumstances in which a family member will be contacted for appointments or need access to your medical information. **Please list who has your permission to do so:**

Name:_____Phone:_____Relationship:_____

Name:_____Phone:_____Relationship:_____

DO NOT RELEASE information to the following:

_____

Patient Name:_____DOB:_____

Signature of Patient/Parent:_____

Print Name of Patient/Parent:_____Date:_____

***This acknowledgement will be scanned into the patient's permanent EHR.** ***Rev 9/2018**