CONSENT FOR TREATMENT

I, _______________, agree to allow Integrative Pediatrics, Inc. to provide
(Parent/Guardian)

treatment to my child. I understand that this may include individual therapies, testing or other services that may be considered appropriate or necessary to his/her treatment. I have the right to an explanation as to the nature and purpose of the services my child receives and to have my questions about these services answered. I have the right to withdraw this consent at any time by submitting such withdrawal in writing to Integrative Pediatrics, Inc.

I understand that any information regarding my child is confidential and is not available to individuals or agencies outside of those permitted under the guidelines of the Health Insurance Portability and Accountability Act of 1996. Information about my case may be discussed by the professionals within the Center, and with other professionals who may be treating, or may have treated my child, for the purposes of diagnosis, treatment planning, or payment.

There are some circumstances where information concerning my child may be required to be released without my prior consent. These are:

- A valid court issues a subpoena concerning my records.
- A valid medical emergency occurs.

I have read and understand what is written above.

_______________________________ _______________________________
Signature of Parent/ Guardian Patient Name

____
Print name of Parent

Date: _________________________

Form: CT090106