Consent to Treatment and Use of Health Information

Wayland Pediatrics
Boston Children's
Primary Care Alliance

waylandpediatrics.com
508-358-2918 | *fax* 508-358-6054

Consent for medical treatment

I allow the healthcare providers of Wayland Pediatrics to give the patient named below medical care, including medical examinations, diagnostic testing/procedures, administration of medications, treatment, and other medical services as determined by the provider. I understand that absent emergency circumstances, major therapeutic/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 Wayland Pediatrics 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 Wayland Pediatrics 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 Wayland Pediatrics. 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:

Wayland Pediatrics 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 (MassHIway), Massachusetts Immunization Information System (MIIS}, EpicCare Link, Care Everywhere, and others. I agree that Wayland Pediatrics can use these platforms to share the patient's medical information. I have been provided with a copy of the Wayland Pediatrics Notice of Privacy Practices that describes other uses and disclosures of health information.

Acknowledgment

This approval will remain in effect until the patient leaves Wayland Pediatrics.

Signature of parent/guardian, or patient if over 18:

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Date: _____