Fox River Pediatrics

When it comes to your child's health, we care

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CONSENT/AUTHORIZATION FORM

Ayezah Mir, M.D., F.A.A.P.

CONSENT FOR TREATMENT: I authorize the above named physician to treat/perform procedure(s) along with the expected benefits, risks and/or consequences involved in:

1. Physical Exams
2. Vaccinations/Treatment as needed

I understand that the treatment will be explained to me in detail and the physician will answer my questions. Understanding this, I authorize the above named physician to perform such exams, treatment, lab tests and administer such medicines as in her opinion, necessary for

____
(Name of patient/minor)

RELEASE OF MEDICAL RECORDS: In order to ensure proper follow up and continuity of care, I agree that a copy of my medical records may be released to my physician, a designated referral physician and/or the provider, if any, who referred me here.

INSURANCE AUTHORIZATION: I request that payment of authorized benefits be made to the above physician on my behalf, for any services provided to me. I authorize any holder of medical and other information pertaining to me, to be released to Medicare assistance agency, or any other governmental/private payer responsible for paying such benefits, any information needed to determine these benefits or benefits related to services. I agree to pay all charges not covered by third party payer. I authorize a copy of this form to be used in place n the original as needed.

SIGNATURE: ____