BEY-YU C. HILGART, M.D.
PRASHANT G. DESHPANDE, M.D.
V. GRACE CARREON, M.D.
JONATHAN L. BELGRAD, M.D.
ELIZABETH C. STRINGER, M.D.
SURASAK PRATUANGTHAM, M.D.

PATIENTS AGE 18 YEARS OR OLDER
CONSENT FOR DISCLOSURE TO FAMILY MEMBER AND/OR PERSONAL REPRESENTATIVE

Patient Name: _____ Birth date: _____ Cell_____

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for the Southwest Pediatrics staff to disclose my personal medical information to the following individual(s):

Name: _____Relationship to Patient: _____ Phone# _____

Name: _____Relationship to Patient: _____ Phone# _____

Name: _____Relationship to Patient: _____ Phone# _____

Conditions for Disclosure (Check the item(s) that apply):

□ Southwest Pediatrics may disclose my medical information to the individual(s) above when I am not physically present, including disclosures by telephone, facsimile, e-mail or regular mail.

Please note:

Southwest Pediatrics will not disclose confidential information without a specific release.

See release below.

I authorize the release of information relating to:

□ Alcohol / Drug Abuse Evaluation/Treatment

□ HIV / AIDs / STD Evaluation/Treatment

□ Psychiatric / Mental Health Evaluation/Treatment

□ Pregnancy Evaluation/Treatment

_____ I WISH MY MEDICAL RECORD TO BE VIEWED ONLY BY ME.

I understand that this consent may be revoked by me at any time by written notice to the practice.

Patient Signature: _____ Email: _____

Date of Signature: _____

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Mokena, IL 60448
(708) 479-7337
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Answering Service
(708) 857-2844

www.southwestpeds.com

Office use: Location: Patient Docs Name: 18+ Consent Billing Alert: 18+ Consent Signed mm/dd/yy initials