Childs Name: ______________________________________

DOB: ____/_____/________

ACKNOWLEDGEMENT AND AUTHORIZATION:

I have read and understand the HIPAA/Privacy Policy for CHILDREN'S HEALTH SERVICES, PA

I hereby assign my insurance benefits to be paid directly to the healthcare provider

I authorize CHILDREN'S HEALTH SERVICES, PA to release medical information required to process my claim

I have read and understand the Financial Policy for CHILDREN'S HEALTH SERVICES, PA

I authorize CHILDREN'S HEALTH SERVICES, PA., to obtain/have access to my medication history.

I authorize my provider's office to contact me by mobile phone.

Signed_______________________________________ Date: ________________