PCS PEDIATRIC COMMUNICATION SOLUTIONS
FIND YOUR VOICE

Authorization for treatment

I hereby authorize the provider(s) in charge of the care of the patient of Pediatric Communications Solutions, Inc. to administer treatment as may be deemed necessary or advisable in diagnosis and treatment of this patient.

Authorization for release of medical information

I hereby authorize the provider(s) of Pediatric Communication Solutions, Inc. to disclose any or all of the information in my medical records to any person, corporation or agency which is or maybe liable for all or a part of Pediatric Communication Solutions, Inc. charge or who may be responsible for determining the necessity, appropriateness, amount or other matter to the provider's treatment for charge including, carriers, welfare funds, the Social Security Administration of its intermediaries or carriers. **I understand my my medical records may contain information that indicates that I have a communicable disease which may include but is not limited to, disease such as hepatitis syphilis, gonorrhea or human immunodeficiency virus, also known as acquired immune deficiency syndrome (Aids).** With this knowledge, I give consent to the release of all information my medical records, including information concerning identity comments and release pediatric communications solutions, its agents and its it employees from liability in connection with the release of the information contained therein.

Assignment of insurance benefits

I hereby authorize payment directly to my provider(s) of the medical insurance benefits otherwise payable to me for services rendered during my visit at Pediatric Communications Solutions, Inc. I understand I am financially responsible for charges not covered by this assignment.

You agree that, to the fullest extent permitted by law, we may remit all or a portion of any credit balances for other amounts do to you from us to any of our affiliates to whom you owe a balance for fees, items for services. We will advise you of any payments we make on your behalf to our affiliates.

Waiver of the responsibility of valuables

I hereby release Pediatric Communication Solutions, Inc. from any claim for a responsibility of damages in the event of loss of my property, including money and jewelry.

I understand a photo copy of this document is as valid as the original.

Signed_____Date_____
(PATIENT)

Or_____
(nearest relative or responsible party)

_____ Policyholder's signature_____
(relationship to patient)

NOTICE TO PATIENTS: information in your medical records that you have/may communicable or venereal disease is made confidential by law and cannot be released without your permission, except in limited circumstances, including release a person who have had risk exposure, release pursuant to an order of the court of the Department of health, release among healthcare providers for released for statistical or epidemiological purposes. Such information is released, it cannot contain information from which you could be identified unless release of that identifying information is authorized by you, by the Court, or the department of health, or by law.