

KENT PEDIATRICS
4735 West River Dr.
Comstock Park, MI 49321

GENERAL CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

Patient Name: _____ Date: _____

1. **Consent for General Treatment.** I request and authorize healthcare services to be provided by Kent Pediatrics. This includes but is not limited to administrations of drugs, laboratory procedures, routine medical care, nursing and other patient care.
2. **No Representations of Guarantees.** I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no oral or written representations or guarantees have been made to me as the results of any diagnosis, treatment and medical care that I (or patient) may receive as a patient at Kent Pediatrics.
3. **Teaching facility.** I am aware that Kent Pediatrics operates and assists in teaching programs and participates in approved medical research. I consent to the observation of my diagnosis and treatment and the review of my medical records for the purposes of providing an essential part of training for these students. I understand that this will be done with dignity and my need for confidentiality and any identifying information shall not be published without prior consent.
4. **Consent to Retain or Dispose of Bodily Fluids and Tissues.** I hereby authorize Kent Pediatrics to retain, preserve, and use for the furtherance of medical research and knowledge of teaching purposes, or otherwise dispose of at their convenience any specimens or tissues as a result of the procedure(s).
5. **Release of Information.** I authorize Kent Pediatrics, its agent, employees, and medical staff to release copies of my medical records, including information from prior treating and/or referring physicians and hospitals and other healthcare providers or diagnostic centers, x-rays, reports, and information about substance abuse treatments, mental illness, HIV infection, acquired immunodeficiency syndrome/related complex, venereal disease, or tuberculosis.
 - a. To any governmental agency, billing services, insurance company, auditing agency engaged by Kent Pediatrics or a third party payer, employer or physician for the purpose of processing any claims for benefits.
 - b. To any physician or healthcare facility to which I (or patient) may be referred to for the purpose of continuing patient care.
 - c. The data-sharing may be through provision of written medical information or through electronic sharing of information.
6. **HIV Testing (AIDS Virus).** I acknowledge that I am notified pursuant to Michigan law, that I may be tested for the presence of HIV, HIV antibody, Hepatitis B and Hepatitis C without my consent if any health professional or other facility employee sustains a needle stick, mucous membrane or open wound exposure to my blood or other body fluids. This test is permitted by Michigan law, and is for my protection as well as the protection of the physicians, nurses, other employees, and other healthcare professionals.
7. **Personal Property.** I agree and acknowledge that Kent Pediatrics has no responsibility for loss of clothing, money, valuables, glasses, or any other personal items of mine and understand that arrangements should be made by me to safeguard items while in the office.
8. **Notice of Privacy Practices.** I acknowledge that I have received the Notice of Privacy Practices.

I hereby certify that I have read this form or it was read to me, that this form was explained to me on the date written and that I fully understand the contents of this form.

Signature of Patient, Parent or Responsible Party

Relationship to Patient