Kelly Hughes, D.O **Eric Nyman, M.D.** **Sara Emerick, M.D.**
2175 N. Alma School Rd Ste C104 – Chandler, AZ 85224

Release of Protected Health Information

For Billing/Medical Claims Purposes

I _____ authorize **ASSIGNMENT OF BENEFITS** from any and all insurance payable for
(name of parent/responsible party)
Medical care rendered to my child. **Photocopies** are valid as originals. **I authorize release of my PROTECTED HEALTH INFORMATION** required by insurance carriers to **BETHESDA PEDIATRICS/AINSWORTH CONSULTING GRP, LLC** for purposes of submitting claims and collecting payment. If any proceedings or actions shall be brought against me to recover any outstanding balance, the undersigned agrees to pay all costs and expenses acquired including reasonable attorney's fees. I understand by signing this physical form I am giving permission for the Practice for electronic signatures when sending, rebilling and any claim related activity.

I am aware of the **Notice of Privacy Practices** which has been given to me or posted with the office for my review. I further understand that I can request that my **Protected Health Information** be limited by requesting so in writing to the Privacy office. I understand that this authorization meets the needs of HIPAA (Health Insurance Portability and Accountability Act) guidelines set forth by the Federal government in regards to patient confidentiality.

_____ _____
Parent/Guardian/Responsible Party's Signature **Date**

Consent For Treatment

I _____, give permission to **BETHESDA PEDIATRICS**
(name of parent/guardian/responsible party)
(Eric Nyman M.D, Dr. Kelly Hughes & any covering Provider) to care for and treat my child. I understand that my child cannot be treated without my presence unless I've given written consent to an adult **OVER THE AGE OF 18** to seek such care or treatment.

In my absence the following adults **OVER THE AGE OF 18** may seek medical attention for my minor child:

Name: _____ **Relationship to Child:** _____

Name: _____ **Relationship to Child:** _____

Name: _____ **Relationship to Child:** _____

I may be reached at the following phone number to discuss my child's care and/or treatment:

(_____) _____ - _____

_____ _____
Parent/Guardian/Responsible Party's Signature **Date**

Received By (BETHESDA PEDIATRICS): _____

Revised 06-27-2014