

MAUMEE PEDIATRIC ASSOCIATES
Consent for Purposes of Treatment, Payment & Healthcare Operations

- I have received a copy of Maumee Pediatric Associates' Notice of Privacy Policies.
- Maumee Pediatric Associates has my permission to leave voice messages at the phone numbers listed on my child's account regarding upcoming appointments or test results. I also grant MPA permission to fax any pertinent information, upon my request, to the schools of my choice for their records.
- If a person other than a parent or legal guardian presents my child for treatment, MPA can reasonably assume they have my permission to seek treatment. Information regarding my child will only be given in person or over the phone to those individuals listed below:

| | |
|--|--|
| | |
| | |

Please list all patients for which this document pertains to:

| | |
|--------------|-----|
| Patient Name | DOB |
| Patient Name | DOB |
| Patient Name | DOB |
| Patient Name | DOB |

| | | |
|-----------------------------|----------------------------|------|
| Signature of Representative | Relationship to Patient(s) | Date |
|-----------------------------|----------------------------|------|