



Patient Consent for Treatment & Use and Disclosure of Protected Health Information

Consent to Treatment and Examination

With this consent, I voluntarily give authorization for my medical treatment or my child's medical treatment to the providers at Dawson Pediatrics, P.C. Permission is hereby given for patient(s) listed to receive any medical/surgical procedure, x-rays, drug, or laboratory test, medication or exam, as may be deemed necessary by the physicians.

I fully understand that payment is required at the time of service, and should my claims be filed to my insurance company, any unpaid balance is my responsibility. When necessary, I further authorize the release of medical records to my insurance company. In the event that the physician files to my insurance, I authorize benefits to be paid directly to the physician.

Consent for Use and Disclosure of Protected Health Information

I hereby give consent for **DAWSON PEDIATRICS, P.C.** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided by Dawson Pediatrics describes such uses and disclosures more completely.)

With this consent, DAWSON PEDIATRICS, P.C. may call my home or other alternative location and leave a message on voice mail, answering machine, or with a person in reference to any items that assist the practice in carrying out TPO. Such items include appointment reminders, insurance items, and any calls pertaining to my child's clinical care. DAWSON PEDIATRICS, P.C. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, test results and patient statements. With this consent, DAWSON PEDIATRICS, P.C. may also send email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, test results and patient statements.

I have been offered a written copy of the **Notice of Privacy Practices** of DAWSON PEDIATRICS, P.C. prior to signing this consent. DAWSON PEDIATRICS, P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices will be posted in the office or may be obtained by forwarding a written request to the Privacy Officer, Dawson Pediatrics 300 Dawson Commons Circle, Ste 320 Dawsonville GA 30534.

I have the right to request, in writing, that DAWSON PEDIATRICS, P.C. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, DAWSON PEDIATRICS, P.C. may decline to provide treatment to me.

Use of Information for Counseling Services (Minor Privacy Rights in Georgia)

Under Georgia law, minors (children under the age of 18) have the right to seek and receive mental health counseling without parental consent in certain circumstances. These include:

- If the minor is 12 years or older and seeking mental health services related to substance abuse, mental health, or emotional well-being.
- When the minor is a victim of abuse.
- When the minor poses danger to themselves or others.

In such situations, the minor's privacy is protected, and their mental health records may not be disclosed to parents or guardians without the minor's consent, except in situations where there is a threat of harm to the minor or others.

Confidentiality of Counseling Records

In compliance with Georgia law, if your child receives counseling or mental health services, their information will be kept confidential. However, we may disclose information in the following situations:

- If there is a risk of harm to the minor or others.
- If mandated by law or a court order.
- For coordination of care with other healthcare providers, with the minor's consent.

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

Dawson Pediatrics, PC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Dawson Pediatrics, PC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Dawson Pediatrics, PC:

- Provides free aid and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages
- If you need these services, contact Stephanie Pierce



If you believe that Dawson Pediatrics, PC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Stephanie Pierce, Administrator, 300 Dawson Commons Circle, Suite 320, Dawsonville, GA 30534, 706-216-2771, Fax 706-216-2944, spierce@dawsonpediatrics.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Stephanie Pierce, Administrator, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human
Services 200 Independence
Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

~ Parent/Guardian Signature (unless 18 yrs or older) _____ Date _____

~ Relationship to Patient: _____

Internal Use Only:

If a patient or patient's representative refuses to sign the Patient consent for Use and Disclosure of Protected Health Information, please document the date and time the notice was presented to patient and sign below.

Presented on (date & time): _____ by (name & title): _____

Revised: 2025