Blanchard Valley Pediatrics, Inc.
1818 Chapel Drive Suite D
Findlay, OH 45840
Phone: 419-424-1922 Fax: 419-424-1927

CONSENT FOR TREATMENT AND HEALTHCARE OPERATIONS

Consent to the use or disclosure of my protected health information by Blanchard Valley Pediatrics, Inc. for the purposes of diagnosing or providing treatment to my children, obtaining payment for my healthcare bills or to conduct the healthcare operations of Blanchard Valley Pediatrics, Inc. and healthcare providers. By my signature on this document I further authorized treatment by the physicians and healthcare providers of Blanchard Valley Pediatrics, Inc. I agree to provide a current insurance information and to cooperate with coordination of benefits.

Name of Patient_____Date of Birth_____

I, _____(parent and/or guardian) give permission for the following to receive any medical or financial information from the office of Blanchard Valley Pediatrics, Inc.,

Spouse_____Child Care Provider_____

Grandparent_____School_____

Additional_____Additional_____

Additional_____Additional_____

Cell Phone_____
Voice Mail/Answering Machine_____
Fax_____
Work Number_____
E-mail Address_____

I understand it is my responsibility to notify BVP of any changes to the above info.

Authorized Signature_____Date_____

Blanchard Valley Pediatrics, Inc.
Notice of Privacy Practices for Protected Health Information
Acknowledgement of Receipt of Notice of Privacy Practices

I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

Patient's Name_____

Patient/Parent/Guardian Signature_____Date_____