ADMISSION DATE REFERRAL SOURCE FAMILY NUMBER

NAME DATE OF BIRTH

ADDRESS PHONE

RACE SEX

MOTHER AGE

FATHER AGE

GUARDIAN

MARITAL STATUS S M D W SEPARATED

PLACE OF EMPLOYMENT

HEALTH COVERAGE

FAMILY CASE NUMBER

SSN

AUTHORIZATION AND RELEASE

I understand that the clinic may decline to provide medical services to my child due to limited facilities.

I authorize that immunizations and diagnostic testing be given to my child.
This will be discussed with me before administration.

I consent to a release of information to insurance companies and authorize payment directly to Margaret B. Shipley Child Health Clinic, Inc.

I have received a copy of HIPAA policies.

☐ YES ☐ NO Margaret B Shipley Child Health Clinic may leave messages on my voice mail or answering machine for reminders of an upcoming appointment.

☐ YES ☐ NO Margaret B Shipley Child Health Clinic may leave messages on my voice mail or answering machine concerning medical issues for my child.

I HAVE READ THIS AUTHORIZATION AND RELEASE. I HAVE BEEN ABLE TO ASK QUESTIONS AND I UNDERSTAND WHAT I AM SIGNING. I HAVE BEEN OFFERED A COPY OF THIS AUTHORIZATION AND RELEASE.

Signature/ Relationship Date

Witness Date