Cameron S. Schaeffer, M.D., PSC

Consent to Treat

I hereby authorize Cameron S. Schaeffer, M.D., PSC, and its employees, to provide medical care to my child, listed below, including examinations and treatments both within its office and at other locations. I certify that I am the legal parent or guardian, and I understand that Cameron S. Schaeffer, M.D., PSC assumes that a child's biological and/or legal parents are both legal guardians who have access to medical information and treatment options for that child. Any child brought to our clinic by someone other than the child's parents and or legal guardians for examination or treatment must have a signed authorization from the parents or legal guardians. This authorization gives Cameron S. Schaeffer, M.D., PSC the right to share the child's protected health information with the person(s) who accompany the child to our office.

Medical Records/ Privacy

At Cameron S. Schaeffer, M.D., PSC, we are committed to protecting the security and privacy of your child's personal information. Medical records are our property, kept in a secure location, and are accessed only for purposes outlined by the **Notice of Privacy Practices**. Records may be released or shared with other health care providers or third party payers for treatment of your child. Patients are entitled to one free copy of their medical records only after an authorization for release is signed. Additional copies may be made for a fee.

- I understand that Cameron S. Schaeffer, M.D., PSC may contact me at home or at my place of employment by mail, phone, fax, or email for health care reasons, appointment reminders, or to resolve billing issues. Use of email will not include the provision of health care, but will be limited to appointment reminders and billing issues.
- I understand that Cameron S. Schaeffer, M.D., PSC may leave messages on my answering machine regarding appointments and limited lab information.
- I authorize Cameron S. Schaeffer, M.D., PSC to discuss my child's medical case with adults or other minors present during the visit regardless of whether I am present.
- I understand that if I send photograph(s) of my child(ren), Cameron S. Schaeffer, M.D., PSC may display them within the office.
- I understand that any signed artwork created by my child may also be displayed within the offices of Cameron S. Schaeffer, M.D., PSC.
- I understand that Cameron S. Schaeffer, MD., PCS will fax letters of consultation and other information to my PCP or Referring MD.

I acknowledge that I have been offered and have received a copy of Cameron S. Schaeffer, M.D., PSC's Notice of Privacy Practices and Consent to Treat information. I understand that I may edit any of the above items.

_____	_____	_____
Patient	**Parent**	**Date**