Authorization of Treatment

Patient Name: _____ Date of Birth: _____ Date: _____
Sex: ☐ Male ☐ Female ☐ Other / Unknown

Address: _____ City: _____ State _____ Zip: _____

School: _____

Insurance Type: _____ Policy #: _____

Parent / Guardian Name: _____ Phone #: _____
Email: _____

I authorize Eastchester Family Services (EFS) to provide the following services:

Physical / Sports Physical	Immunizations	Hearing Screening
Vision Screening	Sick Visit	Lab Services

I allow EFS to file for insurance benefits as applicable to pay for the care my child will receive.

Patient confidentiality is important at EFS therefore, we ask you to provide us the following information:

Name of any other family member or party that you authorize to speak to staff, schedule appointments and/or receive personal health information concerning your child:

Name: _____ Relationship to Patient: _____

Any party NOT listed above will **NOT be able to access any of your child's protected health information until this authorization is updated by the parent or legal guardian.*

**Photo ID will be required from anyone listed above receiving personal health information concerning the patient from EFS.*

If I am unable to be reached at the primary number listed above and/or in my child's record, EFS may leave the following information on my voicemail (check all that apply):

☐ Appointment Reminders ☐ Referral/Test Information ☐ Financial Information

By signing below, I authorize EFS to provide above listed services.

_____ _____
Signature of Parent / Legal Guardian Date: