GENERATIONS
FAMILY HEALTH CENTER

☐ **40 Mansfield Ave. Willimantic, Ct 06226 (860) 450-7471**
☐ **42 Reynolds Street Danielson, Ct 06239 (860) 774-7501**
☐ **330 Washington Street/ Suite 510 Norwich, Ct 06360 (860) 885-1308**
☐ **202 Pomfret St. Putnam, Ct 06260 (860) 963-7917**
☐ **35 Wicker Street Putnam, CT 06260 (860) 928-4698**
☐ **Across the Smiles Putnam, CT 06260 (860) 963-7917**

CONSENT BY PROXY FOR PEDIATRIC/CONSERVED ADULT CARE

I_____ hereby consent to and authorize permission for the person/people listed below to accompany my child/conserved adult _____DOB_____ to Generations Family Health Center, Inc. for office visits. The visits may include diagnosis and/or treatment and consent to such as may be deemed necessary in the treatment of my child/ conserved adult. I understand that I will be contacted directly if consent is needed for any in-office procedure which requires separate consent in writing.

The following individual(s),who are at least 18 years old, will provide proper valid identification and will serve as proxy for my child/conserved adult. I have been advised that protected patient health information may be shared with the proxy to facilitate informed decision making. That information is limited to that which must be exchanged during visits at heath center to ensure appropriate care and for the dates of _____to_____.

Name	Relationship	Phone Number

I authorize Generations Family Health Center, Inc. to release/obtain all pertinent information regarding the patient's treatment which may include information relating to medical, psychiatric, alcohol, and drug abuse, HIV/ AIDS, Sickle cell, to such facilities as is necessary for my treatment and care. I authorize Generations Family Health Center, Inc. to release/obtain all pertinent information regarding the patient's treatment, including information relating to treatment for medical, psychiatric, alcohol and drug abuse, HIV/ AIDS, Sickle cell to any third party pay or for the purpose of security payments for services to the physician or organization furnishing the service. This facility, its employees, officers and attending physician are released from legal responsibly or liability for the release of the above information to the extent indicated and authorized therein.

I understand that the patient's alcohol and/or drug treatment records are protected under State and Federal Confidentiality Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (see 42 USC290DD-2 for Federal laws and 42 C.F.R. Part 2 for Federal regulations, and Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without parental or legal guardian consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time, except to the extent that action has been taken in reliance upon it.

I understand that I may revoke this authorization at any time, except where information has already been released pursuant to my authorization, provided that any such revocation is done in writing.

I understand that the information released here may be subject to re-disclosure by the recipient and may no longer be protected by the Health Center's privacy practices or applicable privacy law.

I understand that Generations Family Health Center, Inc. may not condition the patient's treatment on my provision of this authorization.

Signature of Parent or Legal Guardian Date

This form is valid until the Parent or Legal Guardian removes the proxy consent.