Pediatric Partners, PLC
4649 N Breton Ct SE, Suite A
Kentwood, MI 49508

GENERAL CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

Patient Name:_____ Date:_____

1. **Consent for General Treatment.** I request and authorize healthcare services to be provided by Pediatric Partners, PLC (PPPLC). This includes but is not limited to administration of drugs, laboratory procedures, routine medical, nursing and other patient care. If I am an obstetrical patient, I understand that my signature consents to the care and treatment of my newborn.
2. **No Representations or Guarantees.** I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no oral or written representations or guarantees have been made to me as to the results of any diagnosis, treatment and medical care that I (or patient) may receive as a patient at Spectrum Health.
3. **Teaching Facility.** I am aware that PPPLC operates or assists in teaching programs and participates in approved medical research. I consent to the observation of my diagnosis and treatment and the review of my medical records for the purposes of providing an essential part of training for these students. I understand that this will be done with respect for my dignity and my need for confidentiality and any identifying information shall not be published without prior consent.
4. **Consent to Retain or Dispose of Bodily Fluids and Tissues.** I hereby authorize PPPLC to retain, preserve, and use for the furtherance of medical research and knowledge or for teaching purposes, or otherwise dispose of at their convenience any specimens, tissues, parts or organs taken from my (or patient's) body as a result of the procedure(s).
5. **Release of Information.** I authorize PPPLC, its agent, employees, and Medical Staff to release copies of my medical records, including information from prior treating and/or referring physicians and hospitals and other healthcare providers or diagnostic centers, x-rays, reports, and information about substance abuse treatment, mental illness, HIV infection, acquired immunodeficiency syndrome, acquired immunodeficiency syndrome related complex, venereal disease, or tuberculosis.
   a. To any governmental agency, billing services, insurance company, auditing agency engaged by PPPLC or a third party payer, employer or physician for the purpose of processing any claims for benefits.
   b. To any physician or healthcare facility to which I (or patient) may be referred to for the purpose of continuing patient care.

   This release is subject to written revocation at any time to the extent that action has been taken.
6. **HIV Testing (AIDS Virus).** I acknowledge that I am notified pursuant to Michigan law, that I may be tested for the presence of HIV, HIV antibody, Hepatitis B and Hepatitis C without my consent if any health professional or other facility employee sustains a needle stick, mucous membrane or open wound exposure to my blood or other body fluids. This test is permitted by Michigan law, and is for my protection as well as the protection of the physicians, nurses, other employees, as well as other healthcare professionals.
7. **Personal Property.** I agree and acknowledge that PPPLC has no responsibility for loss of clothing, money, valuables, glasses, or any other personal items of mine and understand that arrangements should be made by me to safeguard items while in the office.
8. **Notice of Privacy Practices.** I acknowledge that I have received the Notice of Privacy Practices.

I hereby certify that I have read this form or it was read to me, that this form was explained to me at the date and time above written and that I fully understand the contents of this form.

_____ _____ _____
Signature of Patient, Parent or Responsible Party Date Relationship to Patient

_____ _____
Witness to Signature Date