# Authorization to Treat/Consent Form

I, _____ parent of _____ understand that by signing this form I allow **CLARKSBURG PEDIATRICS, LLC** and their employees my consent to use or disclose mu protected health information to carry out my treatment, obtain payment from insurance companies, and health care operations, such as quality reviews.

I have been informed that I may review the clinic's Notice of Privacy Practices before signing this consent.

I understand that I have the right to request of restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction.

I also understand that I may revoke this consent at any time, by making a request in writing, except for the information already used or disclosed.

**Signature**: _____

**Date:** _____

**Relationship to patients:** _____