Consent to Treat Minor and Clinical Document Exchange Consent

Anshu Dalela, MD

By signing this form, I hereby give my consent for White Cloud Pediatrics to provide medical care and treatment to my minor child, as deemed necessary by the healthcare provider(s) at White Cloud Pediatrics. I understand that this consent will remain in effect until I revoke it in writing.

Additionally, I consent to the use of Clinical Document Exchange for securely sharing my child's medical records with other healthcare providers, such as hospitals, urgent care centers, specialists, and emergency room providers, for the purpose of coordinating care and treatment. This may include sharing information regarding diagnoses, test results, treatment plans, and other relevant medical information. I understand that this exchange of information will occur automatically unless I choose to revoke my consent.

I understand that I have the right to revoke my consent to the Clinical Document Exchange at any time by notifying White Cloud Pediatrics in writing. The revocation of consent will not affect any information shared prior to the withdrawal of my consent.

I acknowledge and consent to the following (Check the boxes that apply)

☐ **Consent to Treat Minor:** I give permission for White Cloud Pediatrics to provide medical care to my minor child, including any necessary examinations, treatments, and diagnostic tests.

☐ **Clinical Document Exchange Consent:** I consent to the secure sharing of my child's medical information with other healthcare providers through Clinical Document Exchange for the purpose of coordinating care.

☐ **I revoke permission** for White Cloud Pediatrics to share my information with other healthcare organizations through Clinical Document Exchange.

Guarantor / Responsible Party's Name: _____

Guarantor / Responsible Party's Signature: _____

Date: _____