

**PROTECTED HEALTH INFORMATION CONSENT AND FINANCIAL RESPONSIBILITY FORM  
EFFECTIVE SEPTEMBER 2008**

**PATIENT INFORMATION:**

Last Name	First Name	Middle Initial	DOB
Address		City	State Zip
Home Phone		Cell Phone	

**PARENT/LEGAL GUARDIAN INFORMATION:**

Name	Phone Number	Relationship
Name	Phone Number	Relationship

**AUTHORIZATION FOR RELEASE OF INFORMATION:** By listing any name you are hereby permitting Lancaster Pediatric Associates, Ltd. to discuss and/or disclose the above Patient's personal protected health information with the individual(s) stated below until the Patient or Parent/Guardian inform Lancaster Pediatric Associates, Ltd. in writing that permission is no longer granted.

Name(s)
Name(s)

**INSURANCE AUTHORIZATION:** I the undersigned authorize payment of medical benefits to Lancaster Pediatric Associates, Ltd. for any services furnished to me by the group. I understand I am financially responsible for any amount not covered by my insurance plans contract. I also authorize you to release to my insurance company information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefit.

Patient and/or Responsible Party Signature	Date
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**Please date and initial if NO CHANGES**

Date	Initial	Date	Initial	Date	Initial	Date	Initial	Date	Initial
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