



Detailed Messages Regarding Healthcare Information Form for Minors

You have the right to authorize UCSF Benioff Children's Physicians (UBCP) providers and staff to leave detailed voice messages regarding your child's health information on an answering machine or other voice recording system. If you authorize UBCP providers and staff to leave detailed voice messages this authorization entitles; hospitals, provider offices, home health, etc. to leave detailed information, which may include medical diagnosis, surgical information, other healthcare services, test results, medication information and treatment of any illness or condition. Detailed message authorization is optional and not a requirement. UBCP will only leave detailed messages regarding health information for the phone number authorized below and will not leave detailed messages at any other numbers in the record. The authorization to leave detailed voice messages will remain valid until withdrawn in writing, unless specified by a calendar date. **There are risks associated with leaving detailed voice messages regarding your child's health information, including, but not limited to, potential disclosure to a third-party. By signing this authorization form you acknowledge and accept the risks associated with this type of release. If your child's health information is disclosed to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.**

Additionally, you have the right to authorize UCSF Benioff Children's Physicians (UBCP) providers and staff to discuss your child's detailed medical information with designated individuals. Such detailed information may include medical diagnosis, surgical information, other healthcare services, test results, medication information and treatment of any illness or condition. This authorization is optional and not a requirement. The authorization to discuss your child's detailed medical information with designated individuals will remain valid until withdrawn in writing, unless specified by a calendar date. Please complete the UBCP Authorization for Release of Health Information Form to authorize designated individuals.

Patient Information	
(1) Patient Name (Last, First):	Date of Birth (DOB):
Date of 18 th Birthday:	
(2) Patient Name (Last, First):	Date of Birth (DOB):
Date of 18 th Birthday:	
(3) Patient Name (Last, First):	Date of Birth (DOB):
Date of 18 th Birthday:	
Parent/Legal Guardian Information #1	
Parent/Legal Guardian Name (Last, First):	
Date of Birth (DOB):	Relationship to Patient:
Parent/Legal Guardian Information #2	
Parent/Legal Guardian Name (Last, First):	
Date of Birth (DOB):	Relationship to Patient:
Today's Date (Date of Authorization):	

Phone Number(s) Authorized for Detailed Messages					
Phone Number	Type			Parent/Legal Guardian	
	<input type="checkbox"/> Home	<input type="checkbox"/> Cell	<input type="checkbox"/> Work	<input type="checkbox"/> #1	<input type="checkbox"/> #2
	<input type="checkbox"/> Home	<input type="checkbox"/> Cell	<input type="checkbox"/> Work	<input type="checkbox"/> #1	<input type="checkbox"/> #2
	<input type="checkbox"/> Home	<input type="checkbox"/> Cell	<input type="checkbox"/> Work	<input type="checkbox"/> #1	<input type="checkbox"/> #2

NOTE: Expiration of authorization automatically occurs on the patient's 18th birthday.

Specific Date(s) (Optional)	
From:	To:

Signature of Parent/Legal Guardian Today's Date

Signature of Parent/Legal Guardian Today's Date

Signature of Witness (required if patient/parent/legal guardian unable to sign) Today's Date

Relationship to Patient



Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given access to a copy of the UCSF Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in the Notice of Privacy Practices, please do not hesitate to contact a clinic representative. Also, a copy is posted on our website at www.UBCP.org.

Printed Patient Name

Date of Birth (DOB)

If Patient is a Minor, Printed Parent/Legal Guardian or Financial Guarantor Name

Relationship to Patient

Signature of Patient or Parent/Legal Guardian

Today's Date (Date Noticed Received)



Terms and Conditions of Registration, Medical Services and Financial Agreement

1. UCSF Benioff Children's Physicians (UBCP) is part of the University and is comprised of its hospital(s), medical center(s), its hospital-based clinics, and the UCSF School of Medicine.
2. **MEDICAL CONSENT:** I consent to medical treatments or procedures x-ray examinations, drawing blood for tests, medications, injections, taking of medical photographs, videotaping and laboratory procedures.
3. **RELEASE OF MEDICAL INFORMATION:** The State of California information Practices Act requires UBCP to provide the following information to individuals who supply information about themselves. As a patient of UBCP, I will be asked to submit certain personal information, such as my address and phone number, Social Security number, insurance information, medical history and treatment. The principal purpose for requesting this information is to ensure accurate identification, continuity of medical care, and payment for such care. Under the authority of The Federal Privacy Act of 1974, Article IX, Section 9 of the California Constitution, the California Information Practices Act (Civil Code 1798 et seq.), California Code of Regulations, Title 22, Section 70749, UBCP is authorized to maintain this information. As required by UBCP, furnishing all information requested is mandatory unless otherwise noted. I understand that failure to provide such information may affect my medical care and/or insurance benefits and coverage. UBCP will obtain my written authorization to release information about my medical treatment, except in those circumstances when UBCP is permitted or required by law to release information (see UBCP's Notice of Privacy Practices for a description of the specific circumstances under which UBCP may release this information). For example, UBCP may release a copy of my patient record to health care providers, health plans, governmental agencies and workers' compensation carriers. Additionally, I understand that if I am diagnosed with a reportable disease in California, UBCP is required by law to report my diagnosis to the State Department of Health Services.
4. **FINANCIAL AGREEMENT:** I understand that even if I have insurance, I may be financially responsible for some or all of my medical services. For instance, if I have a co-pay, co-insurance or deductible, I agree to pay the amounts I owe. If I do not have insurance that covers the service I receive, I agree to pay UBCP for professional and clinic services. If I am unable to pay, I understand I may qualify for public assistance, special payment arrangements and/or charity care. I also understand that when this agreement is signed by my spouse, parent or a financial guarantor, my spouse, parent or financial guarantor shall be jointly and individually liable with me for payment, including all collection fees (attorneys' fees, costs and collection expenses), in addition to any other amounts due. Unpaid accounts referred to outside agencies for collection bear interest at the current legal rate.
5. **ASSIGNMENT OF BENEFITS (INCLUDING MEDICARE BENEFITS):** I authorize and direct payment to UBCP of any insurance benefits including hospital insurance and unemployment compensation disability benefits otherwise payable to or on my behalf for UBCP, including emergency services, at a rate not to exceed UBCP actual charges. I understand that I am financially responsible for charges not paid pursuant to this agreement. I further agree that any credit balance resulting from payment of insurance or other sources may be applied to any other account owed to UBCP by me.

I have read, agreed to and received a copy of this Terms and Conditions of Service:

Printed Patient Name	Today's Date
Signature of Parent/Legal Guardian or Financial Guarantor	Today's Date
Signature of Witness (required if patient/parent/legal guardian/financial guarantor unable to sign)	Today's Date
Relationship to Patient	
Signature of Interpreter (if applicable)	Today's Date
Language Used	



Consent to Treatment of a Minor

I, _____, parent or legal guardian of
(Printed Name of Parent/Legal Guardian)

_____, born on _____
(Printed Name of Patient) **(Patient's Date of Birth)**

do hereby consent to any medical care and administration of anesthesia, lifesaving procedures and/or medications determined by a physician to be necessary for the welfare of my child while my child is under the care of an UBCP clinical facility. This authorization is effective from _____ until
(Today's Date)
consent is withdrawn.

Signature of Parent/Legal Guardian

Today's Date

Other Adult Consent to Treatment (Optional)

I, _____, parent or legal guardian of
(Printed Name of Parent/Legal Guardian)

_____, born on _____
(Printed Name of Patient) **(Patient's Date of Birth)**

do hereby authorize _____ to act as my agent to consent to any
(Printed Name Agent/Other Adult)
x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and any other hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, a licensed physician and/or surgeon regardless of where treatment is provided. This authorization is given pursuant to the provisions of Family Code section 6910 and is effective from _____ until consent is
(Today's Date)
withdrawn.

Signature of Parent/Legal Guardian

Today's Date