Embrace Pediatrics

Patient Consent Form

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1 Patient Information

Patient full name:		Date of birth:	
Alberta Health Care #:		Phone:	
Parent/guardian:		Relationship:	
Email:			
Address:			

2 Consent for Medical Assessment and Treatment

I consent for Embrace Pediatrics and its physicians, clinic staff, trainees, or authorized health care providers to provide medical care to the patient named above. Care may include history, physical examination, review of growth and development, diagnosis, treatment planning, ordering investigations, prescriptions, referrals, and follow-up communication with other care providers involved in the patient's care. The physician will discuss relevant findings, treatment options, benefits, and important risks when medical decisions are being made.

Initials: _____

3 Collection, Use, and Disclosure of Health Information

I understand that the clinic will collect, use, and disclose personal and health information as needed to provide safe and appropriate medical care. Relevant information may be shared with family physicians, referring physicians, specialists, laboratories, diagnostic imaging centres, pharmacies, hospitals, Alberta Health Services, Alberta Health, Alberta Netcare, billing agencies when required, or other individuals or organizations when required or permitted by law.

Initials: _____

4 Communication Consent

I consent to the clinic contacting me for appointment, clinical, administrative, and follow-up purposes. I understand that email and text messaging may not be fully secure and may carry privacy risks. I understand that electronic communication should not be used for urgent or emergency medical concerns.

- ☐ Phone
- ☐ Voicemail
- ☐ Email
- ☐ Text/SMS
- ☐ Fax when required
- ☐ Secure electronic communication if available

Initials: _____

5 Virtual Care Consent, If Applicable

I consent to receiving care by phone or video appointment when clinically appropriate. I understand that virtual care may not be suitable for every concern and the physician may recommend an in-person assessment. I agree to participate from a private and safe location and understand that visits should not be recorded without consent.

Initials: _____

6 Consent to Obtain Previous Medical Records

I authorize Embrace Pediatrics to request and receive relevant medical records needed for the patient's care from previous or current health care providers, clinics, hospitals, laboratories, schools, or allied health providers when clinically appropriate. This may include consultation notes, growth charts, immunization records, laboratory or imaging results, hospital or emergency records, and developmental, school, psychology, or therapy reports.

Initials: _____

7 Release of Information to Specific Individuals

I authorize the clinic to discuss appointments, forms, referrals, results, or relevant medical information with the person/persons listed below, unless I indicate otherwise.

Name: _____ **Relationship:** _____

Phone: _____ **Name:** _____

Relationship: _____ **Phone:** _____

☐ I do not authorize release of information to anyone other than the legal guardian/patient, unless required by law.
☐

Initials: _____

8 Clinic Policies

- I am responsible for providing accurate contact information and notifying the clinic of changes.
- I am responsible for attending scheduled appointments or cancelling with reasonable notice.
- Missed appointments or late cancellations may result in a fee, if permitted by clinic policy.
- Some services, forms, letters, reports, uninsured procedures, or administrative tasks may not be covered by Alberta Health Care and may require private payment.
- Prescription refills, forms, letters, or school notes may require an appointment or additional time to complete.

Initials: _____

9 Consent for Minors and Mature Minor Considerations

For pediatric patients, consent is usually provided by a parent or legal guardian. Depending on the patient's age, maturity, and the nature of the medical issue, the physician may speak with the child or adolescent privately and may respect confidentiality when appropriate and permitted by law. Confidentiality may be limited if there is concern for serious safety risk, abuse, neglect, or legal reporting requirements.

Initials: _____

10 Acknowledgement and Signature

I confirm that I have read and understood this consent form, have had the opportunity to ask questions, and understand that I may withdraw consent where permitted by law. I understand that withdrawal of consent may affect the clinic's ability to provide care. This consent remains in effect unless revoked in writing or unless a new consent is required.

Patient name

Relationship to patient

Parent/guardian name

Date

Signature

Witness signature

Witness/clinic staff name