Patient Name________________________________

Insurance Release: I give my consent for Highlands Pediatrics to supply information from my medical records to my insurance carriers, including third party vendors or Virginia Medicaid, to allow them to make appropriate payment. I understand I am financially responsible for all charges whether or not paid by my insurance company. I authorize the use of this signature on all insurance submissions.
Immunization Informed Consent: I agree that my child's immunization record, date of birth and address may be shared with other health care providers. I understand that this information will be used by health care providers for the care of my child and for statistical purposes only. I understand the information will be kept confidential.

Signed:________________________________Date:_____________________

Blood Testing Consent: Since 1993 Commonwealth of Virginia has required that if an employee at a physician's office is exposed to body fluids from a patient in a manner that might transmit Hepatitis B, Hepatitis C, or Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immunodeficiency Syndrome (AIDS), that the patient will be tested for these diseases. If such a test is necessary you will be informed of the blood test and you will be given the opportunity to ask any questions at that time. By signing this release you have consented to such testing and consented to the release of the test results to the health care provider who was exposed.
I have read and understood the "Blood Testing Consent"

Signed:______________________________ Date: ____________________