NEW PATIENT

East Louisville Pediatrics

Health Information Privacy and Authorization

Patient's Name (First, MI, Last) _____ Date of Birth _____

In accordance with Federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996 (HIPAA), in order for your healthcare provider and staff of East Louisville Pediatrics (a division of One Pediatrics) to discuss your child's condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to severity of medical condition, the law stipulates the rules may be waived.

_____I DO NOT AUTHORIZE East Louisville Pediatrics to release any or all information concerning my child's medical care to any individual except as set forth above.

_____I DO AUTHORIZE East Louisville Pediatrics to verbally release any or all information concerning my child's medical care to the following individuals:

Can bring for appointments & authorize treatment including immunizations/injections? (circle Yes or No)

Name _____ Relationship _____ Phone Number _____ **Y N**

Name _____ Relationship _____ Phone Number _____ **Y N**

Name _____ Relationship _____ Phone Number _____ **Y N**

_____I authorize my provider and his/her staff to leave DETAILED MESSAGES regarding my child's healthcare information on my answering machine/voicemail at (check all that apply):

_____ Home _____ Work _____ Cell/Mobile _____ Individuals above

_____I prefer that my provider and his/her staff speak with me personally. DO NOT LEAVE MESSAGES.

My preferred contact method regarding:

Medical Issues	_____ Home phone	_____ Cell phone	_____ Work phone	
Appointment Reminders	_____ Text to cell	_____ Home phone	_____ Cell phone	_____ Work phone
Billing Statements	_____ Home address	_____ email address		
Recall/General Notices	_____ Home address	_____ email address	_____ Primary phone	

I acknowledge that East Louisville Pediatrics has provided me a copy of its privacy practices, which provides a detailed description of the uses and disclosures allowed, as well as other rights I have regarding my protected health information. I understand that I have the right to revoke this authorization at any time by written notification to East Louisville Pediatrics, however the revocation will not apply to information that has already been released in reliance upon this authorization. I also understand that this authorization is valid until further notice or written revocation by me. I understand that it is my responsibility to notify East Louisville Pediatrics of changes to my telephone numbers or my preferences regarding telephone messages.

Signature of Parent/Guardian _____ Date _____

Name of Parent/Guardian _____ Relationship _____