Mt. Airy Pediatrics, PC

Acknowledgment of Receipt of Notice of Privacy Practices and Consent Form

_____(Parent/Patient initials) **Notice of Privacy Practices:** I acknowledge that I have received or been given opportunity to review a copy of the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my individually identifiable health information (IIHI) for treatment, payment, healthcare operations. To the extent permitted by law, I consent to the use and disclosure of this information for the purposes described and the permitted uses and disclosures in the practice's Notice of Privacy Practices. I understand that I may contact the Privacy Officer designated on the notice in writing to revoke my authorization at any time or if I have a question or complaint.

_____ (Parent/Patient initials) **Release of Information:** I hereby permit the practice and the physicians or other health professionals involved my child's care to release healthcare information for purposes of treatment, payment, or healthcare operations, for example:

- For Treatment- TO PROVIDE INFORMATION TO ANY OTHER HEALTHCARE PROVIDER AND FACILITY WE HAVE REFERRED A PATIENT TO. With the exception of psychotherapy notes which will require a separate authorization.
- For Payment- TO SEND INFORMATION OR RESPOND TO A HEALTH INSURANCE CARRIER'S REQUEST FOR INFORMATION IN ORDER TO RECEIVE PAYMENT.
- For Healthcare Operations-TO ASSESS AND IMPROVE THE QUALITY OF CARE WE PROVIDE TO OUR PATIENTS, TO REPORT COMMUNICABLE DISEASES, DOMESTIC VIOLENCE OR CRIMINAL ACTIVITY.

_____ (Parent/Patient initials) **Release of Information to Family/Friends**: Our practice may release your child's health information to a friend or family member that is involved in your child's care, or who assists in taking care of your child. For example, you may ask that a family member or friend or employee take your child to the office for treatment, or we may contact you about lab results and leave a message with a family member, friend or babysitter. In this example, the family member or babysitter would have access to your child's medical information.

_____ (Parent/Patient Initials) **Approval to release Immunization Information:** I give my permission for the office to disclose/release proof of immunization to any school/camp/program attended by my child at my request.

Consent to Receive Mail, Phone, Email or Text Messages for Appointment Reminders and Other Healthcare Communications: Patients in our practice may be contacted via mail, phone, email and/or text messaging to be reminded of appointments, to discuss their health and to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders, account balance reminders and other healthcare communications/information at that street address, email or phone number from the Practice.

_____ (Parent/Patient initials) I consent to receive voice, email and text messages from the practice at any phone numbers and emails I designate below, and to any number forwarded or transferred to that number or emails to receive communication as stated below. I understand that this request to receive emails and text messages will apply to all future appointment reminders/ health information unless I request a change in writing.

The phone number(s) that I authorize to receive voice or text messages for appointment and other health reminders, treatment, other information about my health and/or payment for healthcare I received at Mt. Airy Pediatrics, LLP is:
_____Home/Cell/Work (please circle one)
_____Home/Cell/Work (please circle one)

The email that I authorize to receive email messages for appointment reminders and health information, or other information about my health and/or payment for services I received at Mt. Airy Pediatrics, LLP is: _____

Prescription/Health form Pick-up. There may be times when you need a friend or family member to pick-up a prescription order, health form or other medical information from our office. In order for us to release this information to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

_____(Parent/Patient initials) I wish to designate the following family member / friend to pick up an order on my behalf:

Name: _____ Date: _____

Name: _____ Date: _____

_____(Parent/Patient initials) I do not want to designate anyone to pick-up my prescription order/health form from Mt. Airy Pediatrics, LLP.

Patient Name: _____ Date of Birth: _____

This acknowledgement and consent form should be signed by patient, not parent, if patient is 18 years or older.

PRINTED Name of person signing: _____ Relationship to patient_____
Parent/Patient Signature_____Date _____