CONSENT TO USE & DISCLOSE HEALTH INFORMATION (2018)

Modesto Pediatrics

This office is required by Federal Regulations to inform our patients in regards to the use of your child's health information in accordance to the Health Insurance Portability & Accountability Act of 1996 or HIPAA.

PLEASE READ THE FOLLOWING CAREFULLY

I understand that as part of my child's health care, Modesto Pediatrics originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatments, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my child's medical care and treatment.
- A means of communication among health professionals who contribute to my child's medical care.
- A source of information for applying my child's diagnosis and treatment information to my bill.
- A means by which a third-party can verify the services billed to me actually took place.

I understand and have been provided access to a Notify of Privacy Practices that provides a more complete description of information uses and disclosures. This notice is located in the waiting area in plain view & on our website @ www.modestopediatrics.com. I understand that I have the following rights and privileges:

- The right to review the Notice of Privacy Practices prior to signing this consent, allowing treatment, or making payment for services rendered.
- The right to object to the use of my child's health information for directory purposes.

I understand that Modesto Pediatrics uses a computerized state vaccine registry to track immunization requirements and maintain immunization records. We will enroll your child unless you inform us in writing that you do not wish to participate.

As required by *HIPAA* laws, you have the right to request that communication concerning your child/children's health information be made through confidential channels. Modesto Pediatrics will not ask you why you are making your request.

Some form of contact must be provided.

I hereby request the use of the following confidential channels for the communication of information related to the personal health, treatment, or payment for services rendered of the patient/patient's listed below. ***(Please circle one for each form of contact)***

Phone: May we leave messages on your **voice mail** or **answering machine**? **YES NO**

May we leave messages with **another person answering the phone**? **YES NO**

Mail: May we **mail** information to the address listed in the patient's record for **health care or financial reasons**? **YES NO**

If **"NO"** please provide an address that this information may be mailed to:

Address: _____ City/State/Zip: _____

Text: May we **text** information to the **mobile** numbers listed in the patient's record for **health care or financial reasons? YES NO**

e-mail: May we **e-mail** information to the e-mail address listed on the patient's record for **health care or financial reasons? YES NO**

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected protected health information to another entity. I hereby consent to such disclosure for these permitted uses. I also hereby consent to such disclosures via fax.

By signing below, I fully understand and accept the terms of this consent.

Signature: _____ Date: _____

Print Name: _____ Relationship to patient(s): _____

Patient(s) Name(s) & Date(s) of Birth: _____

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