Acknowledgment and Receipt of Notice of Privacy Practices

I have received the Notice of Privacy Practices from Carolina Pediatrics & Adolescent Care, PA which explains how my child's medical information may be disclosed. I understand that I am entitled to receive a copy of this document and a copy has been made available to me.

Signature of Parent/Guardian (X) _____ Date: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This form must be completed in its entirety in order to be considered valid

Patient Name: _____ Date of Birth: _____
Medical Record Number: _____ Last 4 digits of Social Security Number: _____
☐ I authorize Carolina Pediatrics to disclose / release information TO: _____
☐ I authorize Carolina Pediatrics to obtain information FROM: _____
Name of Individual / Organization: _____
Street Address: _____ City: _____ State: _____ Zip Code: _____
Phone Number: _____ Fax Number: _____

The purpose of the disclosure is: ☐ Continued care ☐ Legal ☐ Insurance ☐ Disability ☐ Patient Request
☐ Other _____ **Date(s) of Service:** _____

The medical record provided by or requested by Carolina Pediatrics from all other sources shall include, but is not necessarily limited to, all history and physical info., consults, lab and radiology reports, discharge summaries, operative / procedure reports, emergency room records, Occupational / Physical Therapy, Postpartum and all medical records of any named medical provider, hospital or urgent care facility.

The following additional information may be requested:
☐ Films / images ☐ Immunization records ☐ Medication list ☐ Physician progress / visit notes
☐ Physician orders ☐ Nurses notes ☐ Entire reord ☐ Other:

I understand this information may include reference to psychiatric / psychological care, sexual assault, drug abuse, results of tests for all infectious diseases including HIV / AIDS and / or alcohol abuse.

I authorize the exchange of this information via (check preferred method): ☐ mail or ☐ fax (cannot fax to a residence)

I specifically authorize Carolina Pediatrics release of info. concerning Appointment notices, Prescription and Sample Pick, Lab Results, Inquiries on Insurance Information and Notices of Collections. (Before any information is released, we reserve the right to verify relationship and knowledge of patient. Picture ID's may be required when picking up any information).

1. Please list the family members of other persons, if any, who have permission to bring your child to our office:
   _____
   _____
   _____

2. Please list the family members or other persons, if any, who we may inform about your child's general medical condition and diagnosis (including treatment, payment and health care operation):
   _____
   _____
   _____

3. Please list the names of any family member or other person, if any, who is expressly **excluded** from acting as your child's personal representative as it pertains to your child's general medical condition, care, treatment, payment and health care operations. NOTE: (Exclusions are honored in accordance with local and State laws which govern parental rights, custody and guardianship. Exclusions when permissible will remain in effect until revoked or superseded by court order or other legally enforceable document:
   _____
   _____
   _____

Any excluded family member or other person listed above (#3) shall not be granted access to medical records except as may be required by law.

In accordance with Continuity of Care, Carolina Pediatrics, PA requests that necessary records and health information be obtainable with ease. Carolina Pediatrics may leave messages on my voice mail recorder at home, mail notices to my home address, call me at work, leave messages on my cell phone, or contact me by e-mail address if provided.

I hereby authorize any attending or consulting provider to release information concerning treatment to any insurance company requesting the same for purposes of determining eligibility for payment of insurance benefits, AND I hereby authorize and assign payment to Carolina Pediatrics for charges associated with my treatment or diagnosis for any benefits specified and otherwise payable to me, but not to exceed reasonable and customary charges. I understand that I am financially responsible to Carolina Pediatrics for any charges not covered by this assignment of benefits.

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand I may review and / or copy the information to be disclosed, as provided in 45 CFR §164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person / organization receiving the information.

I understand that I have a right to cancel / revoke this authorization at any time. I understand that if I cancel / revoke this authorization I must do so in writing and present my written cancellation / revocation to Carolina Pediatrics (Medical Records). I understand that the cancellation / revocation will not apply to information that has already been released in response to this authorization, as stated in the Notice of Privacy Practice. Unless otherwise cancelled / revoked, the authorization will expire / end one year from this date or _____.

I UNDERSTAND THAT FEES FOR COPIES OF MEDICAL RECORDS AND POSTAGE FEES MAY BE CHARGED.
A copy of my identification will be made and attached to this authorization.

_____ _____
Signature of Patient or Legal Guardian / Representative Date

_____
Printed Name of Patient or Legal Guardian / Representative

_____ _____
Relationship to Patient, if signed by Legal Guardian / Representative Witness Signature