Patient Consent for the Disclosure of Information and Acknowledgement Form (HIPAA)

I understand that by signing this form I acknowledge consent to the following:

1. The Notice of Privacy Practices Containing a complete description of the uses and disclosures of my health information has been made available to me and I have had an opportunity to read and review all contents of said document.

2. Sharing information for the purpose of treatment:
   You will share my information with all members of my treatment team, both within this office and with other providers (personal and Institutional) in order to provide me or my child with quality care and educational/wellness programs specified by my insurance plan. This will include communication with our team in verbal and non-verbal form such as postcard reminders, recognition boards, sign in information, and forms of communication for patient care and office visits.

3. Sharing information for purposes of payment:
   You will share all necessary information with mine or my child's insurer(s), governmental entities, and their representatives (including, but not limited to benefit determination and utilization review) as well as your representatives involved in the billing process companies, and in extreme situations, credit bureaus or collection agencies.

4. Sharing of information for the purposes of operations:
   You will share all information necessary for ongoing operations of this office, including (but not limited to) the credentialing processes, peer review, accreditation, and compliance with all federal and state laws

I also understand that by signing this form, I give this office permission to leave messages on my answering machine or voicemail or with a relative regarding: notification of appointments, messages to call the office, test results, and any other information pertaining to mine or my child's healthcare.

Information may be left with:

Name _____
Address _____
_____
Phone Number _____
Relationship to Patient _____

Name _____
Address _____
_____
Phone Number _____
Relationship to Patient _____

I understand that you will be unable to release ANY information to anyone other than the person/persons listed above. I authorize the Temporary Guardian, in the event that I cannot be contacted or if any urgency dictates, to act *in loco parentis* for the Child in respect of any circumstances, including any accident or illness, which may necessitate medical treatment, including surgery, and on my behalf to authorize any such treatment or surgery which they, in their sole discretion, (which discretion shall not be unreasonably exercised), may deem necessary. Medical treatment for the Child may also include dental surgery, x-ray, blood transfusion, anesthetic and medication provided any such medical treatment is performed by a duly licensed practitioner. I hereby accept full liability for all costs incurred through such medical treatment for the Child.

My consent is freely given.

_____ _____
Patient's Name Date of Birth

_____ _____
Patient / Parent / Guardian Signature Today's Date