Owensboro Pediatrics
Partners in Parenting

HIPAA: Authorization of Use and Disclosure of Protected Health Information
Acknowledgment of Review of Notice of Privacy Practices
Office Policy

Date:_____

Childs Name:_____Childs Date of Birth:_____
Last Name First Name MI

How would you like to be contacted regarding appointments, treatment, and/or other important information pertinent to your healthcare and/or payment for your healthcare provided at Owensboro Pediatrics? (Please check all that apply)

☐ Regular Mail ☐ Home Telephone ☐ Work Telephone
☐ Cell Phone ☐ Email

If you have an answering machine, may we leave messages regarding appointments, treatment, and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Owensboro Pediatrics?
(Check one) ☐ Yes ☐ No ☐ N/A

Other Uses and Disclosures: Disclosures of your health information or its use for any purpose other than those listed in the "Notice of Privacy Practices" and/or consent requires your specific written authorization. If you change your mind after authorization a use or disclosure of information that occurred before you notified us of your decision, you have the right to request restrictions on use or disclosure of your health information.

I authorize the person(s) listed below to receive all health information about appointments, treatment, and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Owensboro Pediatrics.

Name of Person_____Phone:_____

Name of Person_____Phone:_____

The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

Acknowledgment of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

OFFICES POLICIES-PLEASE READ THOROUGHLY

1. LATE POLICY- IF YOU ARRIVE 15 MINUTES PAST YOUR APPOINTMENT TIME, YOU WILL HAVE TO RESCHEDULE FOR ANOTHER TIME.
2. NO-SHOW POLICY- APPOINTMENTS MUST BE CANCELED 24 HOURS PRIOR TO APPOINTMENT TIME. IF YOU HAVE THREE NO-SHOWS YOU WILL BE DISMISSED FROM OUR PRACTICE.
3. VACCINATION POLICY-VACCINATION RECORDS ARE REQUIRED FOR ALL WELL-CHILD CHECKS AND PHYSICALS.
4. TRANSFER POLICY- ONCE YOUR CHILD'S RECORDS ARE TRANSFERRED TO ANOTHER CLINIC, HIS/HER FILE WILL BE DEACTIVATED IN OUR SYSYTEM AND HE/SHE WILL NOT BE ALLOWED TO RETURN.

I have read and understand this office's policies which explain the terms and conditions of this office in regards to appointments, no-shows, vaccination records, and transfer to another facility.

Signature of Patient or Representative_____ Date_____

Name of Patient or Representative_____Relationship_____