Poole&Thomas
personal pediatric care

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION – 18 YEARS AND OLDER

This office is required by Federal Regulations in inform our patients to the use of your health information accordance to Health Information Portability and Accountability Act or HIPAA.

I understand that as a part of my health care, Poole and Thomas Pediatrics originates and maintains paper records describing my health history, symptoms, examinations, test results, diagnosis, treatments, and any plans for future care or treatment. I understand that this is information serves as:

- A basis for planning my care and treatment.
- A means of communication among health professionals who contribute to my care.
- A source of information for applying my 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 Notice of Privacy Practices that provide a more complete description of information uses and disclosures. This notice is located on our website ptpediatrics.com and is located in paper form at the check-in window of our office. 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 and the right to a paper copy of the Notice of Privacy Practices.
- The right to object to the use of my health information for directory purposes.
- The right to request confidential communications.

I AUTHORIZE POOLE AND THOMAS PEDIATRICS AND ITS STAFF TO DISCUSS MY MEDICAL INFORMATION AS FOLLOWS

INITIAL ALL THAT APPLY

- **For Financial Purposes:** I allow my parent(s) to access my diagnosis and treatment information and to discuss my account. _____
- I allow my immunizations records to be released by fax, email or mail to: Guardians _____ School _____ Self _____
- I allow my treatment plan (i.e., medication, asthma, epi-pens, etc.) to be discussed with: Guardians _____ Self _____
- I allow my office visits to be accessed by: Guardians _____
- I allow my labs to be released to: Guardians _____ Self _____
- With my consent, I allow any "confidential information" including results of STD testing, HIV, AIDS, and Pregnancy testing to be shared with: Guardians _____ Self Only _____

Guardian 1 Name: _____ Relationship: _____

Guardian 2 Name: _____ Relationship: _____

_____ _____

Signature **Date**