Raleigh Pediatric Associates

CONSENT TO USE & DISCLOSE HEALTH INFORMATION FOR PATIENTS 18 YEARS OLD AND OLDER

Must be completed by the PATIENT after turning 18 years of age.

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

PLEASE READ THE FOLLOWING CAREFULLY!

I understand that as part of my health care, Raleigh Pediatric Associates 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 and have been provided access to a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the *Notice of Privacy Practices* prior to signing this consent, allowing treatment, or making payment for services rendered.

I understand that Raleigh Pediatric Associates is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization may refuse to treat me as permitted by Federal Regulations. I understand that Raleigh Pediatric Associates reserves the right to change their *Notice of Privacy Practices.*

NOTE: If the patient grants consent for parental access, the parent may remain Guarantor on the account. However, should the parent refuse responsibility for payment, the patient will be responsible for all balances remaining after insurance is filed.

PATIENT NAME:_____ **CHART #:** _____

DATE OF BIRTH:_____ **PATIENT'S CELL PHONE #:** _____

I consent to the following uses of my medical information: (Please choose 1 option below and initial next to your choice)

_____ I allow the following people COMPLETE ACCESS to my medical records.

_____ _____
Full Name Relationship

_____ _____
Full Name Relationship

_____ _____
Full Name Relationship

OR

_____ I allow the following people access to my diagnosis and treatment information *ONLY as it applies to any charges I incur at RPA.*

_____ _____
Full Name Relationship

_____ _____
Full Name Relationship

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my 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.
I fully understand and accept the terms of this consent.

_____ _____
Signature: **Date:**

01/12/am; Revised 08/12/am; Reviewed 01/15/am; revised 2/19 sgb; rev 5/2019 sgb; rev 1/2020 sgb