TAX ID #: 27-2302575

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS INFORMATION

Patient's Name: ______________________________ ***Date Of Birth:*** ______________________

Patient's Address: ______________________________ ***Tel:*** ______________________

City, State, Zip: ______________________________

Circle all to be disclosed:

- History and Physical Exam
- Consultation Reports
- Progress Notes
- Radiology Reports
- Laboratory Reports
- Immunization Record
- Growth Charts
- Operative Reports
- Medication Records
- Discharge Repots
- Demographics
- All Medical Information

If Other, Please Specify:

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➢ RECORDS RELEASED TO:

[ ] 2315 EAST CHEYENNE AVE. # 100
NORTH LAS VEGAS, NV 89030
TEL: 702-633-4000 *FAX:* 702-633-4346

[ ] 1250 SOUTH EASTERN AVE.
LAS VEGAS, NV 89104
TEL: 702-383-4001 *FAX:* 702-383-4004

❖ This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act (HIPPA) Privacy Standards.
❖ I hereby consent the release of my child's medical records to Mama Mia Pediatrics at the above address or fax.
❖ EXPIRATION: This authorization for release of health information will expire one year from the date signed below.
❖ I may revoke this authorization at any time by notifying Mama Mia Pediatrics in writing. If I revoke the authorization, I understand it will have no effect on action on Mama Mia Pediatrics took in good faith before receiving the revocation.

➢ RECORDS RELEASED FROM:

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Mailing Address: ______________________________ City, State, Zip: ______________________

Tel: ______________________________ Fax: ______________________

______________________ ______________________ ______________________

Signature ***Relationship to Patient*** ***Date***

PATIENT INFORMATION

PATIENT'S NAME: ______________________________

DATE OF BIRTH: ______________________________ SEX: FEMALE [ ] MALE [ ]

RACE (CIRCLE ALL THAT APPLIES) WHITE / HISPANIC / AFRICAN-AMERICAN
OTHER: ______________________________

EMAIL: ______________________________

PHARMACY OF PERFERENCE: ______________________________

PHARMACY ADDRESS OR CROSS STREETS:

____

IF PATIENT IS A MINOR

MOTHER'S NAME: ______________________________ MOTHER'S DATE OF BIRTH: ______________________________

FATHER'S NAME: ______________________________ FATHER'S DATE OF BIRTH: ______________________________

INSURANCE INFORMATION

(INSURANCE WITH YOUR EMPLOYER)

NAME OF INSURANCE	
POLICY # / S.S.#	
NAME OF POLICY HOLDER	
DATE OF BIRTH	
ADDRESS CITY, STATE, and ZIP CODE	
TEL #	
RELATIONSHIP TO PATIENT	

CASH PATIENTS

OUR OFFICE VISITS RATES FROM $105.00 TO $200.00

WE ARE GIVING YOU A DISCOUNT
OFFICE VISIT WILL BE $65.00
(PRICES MAY CHANGE)

IMMUNIZATIONS ARE INCLUDED

ANY OTHER PROCEDURES WILL BE EXTRA CHARGE

I understand that I am financially responsible for any and all charges for medical services, whether or not paid by an insurance carrier or health plan. I understand that it is my responsibility to pay, in a timely manner, any deductible, co-payment and non-covered services and items which may not be covered by a particular insurance plan.
I also authorize Mama Mia Pediatrics or insurance company to release any information required to process my claims.

SIGNATURE: ______________________________ ***DATE:*** ______________________________

IN CASE OF ANY EMERGENCY, I'M NOT ABLE TO BRING MY CHILD

PATIENT'S NAME: ____________________________________

DATE OF BIRTH: ____________________________________

I, ____
(PARENT OR GUARDIAN NAME)

GIVE MY AUTHORIZATION TO TAKE ANY MEDICAL DECISION TO:

NAME: ____

RELATIONSHIP TO PATIENT: ____________________ **TEL #:** ____________________

NAME: ____

RELATIONSHIP TO PATIENT: ____________________ **TEL #:** ____________________

NAME: ____

RELATIONSHIP TO PATIENT: ____________________ **TEL #:** ____________________

NAME: ____

RELATIONSHIP TO PATIENT: ____________________ **TEL #:** ____________________

SIGNATURE: ______________________________ ***DATE:*** ____________________

NOTICE OF PRIVACY PRACTICES

To our patients: This notice describe how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. Please review it carefully. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy: Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realized that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances:

The following circumstances may require us to use or disclose your health information.

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuit and similar proceedings in response to a court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety of the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official.
8. For workers compensations and similar programs.

Your rights regarding your health information:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to medical records department (Mama Mia Pediatrics).
4. You may ask us to amend your health information if you believe it is incorrect or incomplete and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to medical records department (Mama Mia Family Pediatrics). You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint without practice or with the secretary of the department of health and human services. To file a complaint with our practice, contact privacy officer, (Mama Mia Pediatrics). All complaints must be submitted in writing. You will not be penalized for filling a complaint.
7. Right to provide an authorization for other uses and disclosures. Our patient will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies please contact

2315 EAST CHEYENNE AVE. SUITE 100
NORTH LAS VEGAS, NV 89030
(TEL) 702-633-4000 (FAX) 702-633-4346

1250 SOUTH EASTERN AVE.
LAS VEGAS, NV 89104
(TEL) 702-383-4001 (FAX) 702-383-4004

If you would like a copy of this document please ask front desk receptionist.

SIGNATURE: ____________________________ ***DATE:*** ________________

PATIENT MEDICAL HISTORY

SURGERIES / HOSPITALIZATIONS	*YEAR*	*REASON*

CHILDHOOD ILLNESS: (CIRCLE ALL THAT APPLY):

MEASLES	MUMPS	RUBELLA
CHICKENPOX	RHEUMATIC FEVER	POLIO

OTHER PROBLEMS (CIRCLE ALL THAT APPLY):

SKIN	CHEST	HEART
HEAD	NECK	BACK
WEIGHT	EARS	INTESTINAL
ENERGY LEVEL	NOSE	BLADDER
ABILITY TO SLEEP	THORAT	BOWEL
LUNGS	CIRCULATION	DISCONFORT / PAIN

1.	IS STRESS A MAJOR PROBLEM FOR THE PATIENT?	YES	NO
2.	DOES THE PATIENT FEEL DEPRESSED?	YES	NO
3.	DOES THE PATIENT PANIC WHEN STRESSED?	YES	NO
4.	DOES THE PATIENT HAVE A PROBLEM WITH THEIR APPITITE?	YES	NO
5.	DOES THE PATIENT CRY FREQUENTLY?	YES	NO
6.	HAS THE PATIENT EVER TRIED HURTING THEMSELVES?	YES	NO
7.	DOES THE PATIENT HAVE TROUBLE SLEEPING?	YES	NO
8.	HAS THE PATIENT BEEN TO A COUNSELOR?	YES	NO
9.	HAS THE PATIENT HAD A BLOOD TRANSFUSION?	YES	NO
10.	ANY MEDICATION OR FOOD ALLERGIES?	YES	NO

IF YES, PLEASE LIST:

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FAMILY MEDICAL HISTORY

(CIRCLE ALL THAT APPLY)

ASTHMA	HYPERTENSION	ANEMIA	EARLY DEATH
DIABETES	HEART DISEASES	KIDNEY DISEASES	BLOOD DISEASES
TUBERCULOSIS	SEIZURES	DEVELOPMENTAL DELAYS	PHYCHIATRICS PROBLEMS

ANY OTHER MEDICAL PROBLEMS WE SHOULD KNOW ABOUT?

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SIGNATURE: ______________________________ ***DATE:*** ____________________