Pediatric Associates of North Atlanta, P.C.

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PATIENT RECORD OF DISCLOSURE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their **protected health information (PHI)**. The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

____ **Primary Telephone # _____**
____ May leave message with detailed Information
____ Leave message with call back number only

____ **Secondary Telephone # _____**
____ May leave message with detailed information
____ Leave message with call back number only

____ **Pharmacy # _____**
Rx will be called to this number

____ **Written Communication**
____ May mail to my home address
____ May mail to my office address
____ May fax to this number
fax # _____

____ **Electronic Mail Communication** ____ May use this email address

_____

The Privacy Rule (TPO) generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute as adequate records.

NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

IF OLDER THAN 18 YEARS OLD, MY PHI MAY BE RELEASED TO:_____

By signing below I acknowledge having read the Patient Record of Disclosure, Patient Financial Policy and Informed Consent to Routine Procedures/Treatments. I have also been afforded a copy of our HIPAA Policy/Privacy Notice.

ACKNOWLEDGEMENT OF FINANCIAL POLICY: I have fully read the Patient Financial Policy and understand my financial responsibilities under this policy.
AUTHORIZATION FOR TREATMENT: I consent to examination, treatment, and any procedures including emergency treatment deemed necessary and ordered by our physician for my child and I am personally responsible for any charges.
AUTHORIZATION FOR INSURANCE: I authorize the release of any information concerning myself or child to my insurance company regarding treatment for services rendered.
AUTHORIZATION FOR INSURANCE BENEFITS: I authorize my insurance company to send payment directly to Pediatric Associates of North Atlanta, P.C. for services covered by my insurance plan.
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE: I hereby acknowledge that Pediatric Associates of North Atlanta, P.C. has provided me a copy of their Privacy Notice.
AUTHORIZATION TO CONTACT ME: I authorize Pediatric Associates of North Atlanta, P.C. to contact me by either phone, fax, electronic mail, or mail to provide a reminder appointment, gather demographic or insurance information, or to inform me of services or events offered at the facility.

READ ALL THE INFORMATION ABOVE BEFORE SIGNING BELOW
DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS

SIGNED _____ DATE_____

PRINT _____ WITNESS_____