HIPAA Policy

Consent to Treat and the Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health and medical care, Premier Pediatrics, originates and maintains medical and health records describing my or my child's health history, symptoms, examination, test results, diagnoses, treatments, and plans for future care and treatment. I further understand that this information serves as:

- A basis for planning my or my child's care and treatment;
- A means of communicating between the healthcare professionals who contribute to my or my child's care;
- A source of information for applying my diagnosis and treatment information to my bill;
- A means for third party payers to verify that services were billed as actually provided; and
- A tool for routine healthcare operations such as quality and reviewing the competence of healthcare professionals.

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and any information accumulated in the future. I also understand that I do have the opportunity to request an electronic (computer disk) or hard copy of my or my child's medical records.

I hereby authorize Premier Pediatrics and any of its employees or other authorized personnel or agents, to release any medical records or other personal medical information for purposes of determining benefits for services; for purposes of obtaining reimbursement from my insurance company of record, any public agency or any other potential third party. I further authorize Premier Pediatrics including laboratory or diagnostic testing facility performing services on my behalf, to release any of my medical records or other personal or medical information to any employee, authorized personnel, or other agent of any physician, laboratory, or diagnostic testing facility, or other healthcare provider involved in my care or treatment, or purposes of billing and obtaining reimbursement from any payer, for the purpose of developing an appropriate treatment plan or diagnosis, or for the purposes of quality assurance, utilization review or other analyses designed to monitor and maintain a quality of care.

IN AUTHORIZING THIS RELEASE OF INFORMATION, I HAVE READ THE NOTICE TO PATIENTS SET FORTH BELOW AND I UNDERSTAND THAT SUCH INFORMATION MAY INDICATE THAT I HAVE OR MAY HAVE A COMMUNICABLE OR VENEREAL DISEASE, INCLUDING BUT NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODEFICIENCY VIRUS (ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME OR AIDS).

Information may be released to the following:

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Assignment of Benefits: I hereby authorize payment of any benefits for services rendered by Premier Pediatrics to be made directly to Premier Pediatrics. I authorize Premier Pediatrics to refund any overpaid insurance benefits where the overpayment is subject to coordination of benefits.

Patient Acknowledgement: By virtue of my signature below, I hereby acknowledge that I have read and understand all of the above and that I have been given adequate opportunity to ask any questions about the same.

Signature: By signature of a patient below, Patient represents that the patient is 18 years of age or over and is legally capacitated to give consent to treatment and to authorize release of the above information. By signature of a parent or legal guardian below, such individual represents that the patient is under the age of 18 (a minor) or has a court -appointed guardian.

PARENT/GUARDIAN SIGNATURE	DATE
PATIENT NAME	PATIENT DOB
WITNESS SIGNATURE	DATE

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