HEALTHY KIDS PEDIATRICS

Patient's Name _____ Date of Birth:_____/_____/_____

As a result of the Health Insurance Portability and Accountability Act (HIPPA) which is enforced by the US Department of Health and Human Services Office of civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices, or in accordance with your wishes as stated below.

This waiver authorizes HEALTHY KIDS PEDIATRICS to send/give my medical information as noted:

Leave a voice mail recording including my Personal Health Information on my home telephone:

_____Yes _____No

Leave a voice mail recording including my Personal Health Information on my cell phone:

_____Yes _____No

Use of electronic communications systems (ie fax, electronic messaging) to transmit prescription, treatment, disorder related information, lab or other results:

_____Yes _____No

Use of email to transmit treatment or disorder related information which may include a diagnosis, lab or other results to me: _____Yes _____No

Permit the individual stated below (Personal Representative) to receive prescriptions and/or test results: _____Yes _____No

Speak to a family member of my choosing (Personal Representative as designated below) regarding my Personal Health Information: _____Yes _____No

Name of Designated Personal Representative _____

Relationship tp Designated Personal Representative:_____

_____

On this date _____ I received and reviewed HEALTHY KIDS PEDIATRIC'S Notice of Privacy Practices which describes how my medical information may be used. The authorizations made above will remain effective until such time as I notify HEALTHY KIDS PEDIATRICS in writing, by certified mail of requested changes.

_____ _____ _____

Patient Signature Cell Phone # Today's date