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**CONSENT FOR DISCLOSING PROTECTED HEALTH INFORMATION**

**EMAIL**​: I authorize Pediatric Associates to send the following PHI.
 \_\_\_\_\_ ​*Doctor’s Excuse*​ \_\_\_\_\_​*Immunization Record*​ via email.

I understand that email is not a secure method of communication and is not recommended because it increases the risk that an unauthorized person may receive or interpret my child’s or children's’ protected health information. I release Pediatric Associates from any liability for submitting PHI using email upon my verbal request and this signature located on this form below. ​Initial \_\_\_\_

**FAX**​: I authorize Pediatric Associates to fax the following PHI.
 \_\_\_\_\_​*Doctor’s Excuse*​ ​\_\_\_\_\_*Immunization Record*​ to my workplace (if applicable).

I understand that this is not recommended because it increases the risk that an unauthorized person may receive or interpret my child’s or children's’ protected health information. I release Pediatrics Associates from any liability for submitting PHI using my work’s fax number upon my verbal request and this signature located on this form below. Initial \_\_\_\_

**SCHOOL/DAYCARE**​: I authorize Pediatrics Associates to disclose the following PHI.
 \_\_\_\_\_​*Doctor’s Excuse*​ \_\_\_\_\_​*Immunization Record*​ \_\_\_\_\_*Permission for Medication*

Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION, ASSIGNMENT OF BENEFITS AND RECORD RELEASE**

•I consent to my child’s treatment and allow Pediatric Associates to use and release their protected health information for treatment, payment, and healthcare operations as allowed by HIPAA and as described in the Pediatric Associates Notice of Privacy Practices. A copy has been made available to me.

•I understand that my child’s medical information including complete medical records, test results, and billing information may be released to my insurance company and to other medical professionals and/or medical care institutions for treatment and payment purposes.

•I allow payment to be made directly to Pediatric Associates for all medical benefits otherwise payable to me under terms of my insurance.

•I understand that I am financially responsible for paying all co-payments, co-insurance, deductibles, and noncovered services.

•A photocopy of this form shall be considered as effective and as valid as the original.

•I know it is my responsibility to keep Pediatric Associates informed about changes to any of my contact information. Failure to do so may interfere with the ability to contact me concerning my child’s health care.

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Patient/Parent/Guardian Signature Date

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Patient/ Parent/Guardian Printed Name Relationship With Patient

•2601 Laurel Street, Suite 250, Columbia, SC 29204 •Phone: 803.799.9044 •Fax 803.256.8119 •