DuPage Pediatrics, Ltd.

HIPAA – NOTICE OF PRIVACY PRACTICES & RELEASE OF MEDICAL INFORMATION
FOR PATIENTS WHO ARE MINORS

HIPAA
Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office or viewing it at www.dupagepediatrics.com.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. Our practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- Our practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but our practice does not have to agree to those restrictions
- The patient may revoke this consent in writing at any time and all future disclosures will then cease
- Our practice may condition receipt of treatment upon the execution of this consent
- All telephone numbers and email addresses provided may be used by the Practice and those acting on its behalf to communicate with the patient by telephone (including cell phone), text or any automated or prerecorded messages

APPROVAL TO RELEASE IMMUNIZATION INFORMATION
I give my permission to disclose/release proof of immunization to the school attended by this patient.

RELEASE OF MEDICAL INFORMATION: The patient's parent(s) / legal guardian(s), school (for the release of proof of immunization) and insurance company are already included in this HIPAA Authorization. If you authorize any additional individuals or facilities to have access to the patient's protected health information, please list their information below.
I give my permission to release medical information to:

_____

_____

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

Signature of Parent or Legal Guardian: _____

Printed name of person signing: _____

Relationship of person signing to patient: _____ Date:_____

Names of other siblings this applies to: _____