**PINEVILLE** **PEDIATRICS**

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**HIPAA: Authorization of Use and Disclosure of Protected Health Information**

**Acknowledgment of Review of Notice of Privacy Practices**

 **Office Policy**

 Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_

 Last Name First Name MI

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Pineville Pediatrics? (Please check all that apply)

\_\_\_\_ Home Telephone \_\_\_\_ Work Telephone \_\_\_\_ Cell phone \_\_\_\_ Email

If you have an answering machine, may we leave messages regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Pineville Pediatrics?

(Check one) \_\_\_ Yes \_\_\_ No \_\_\_ N/A

Other Uses and Disclosures: Disclosure of your health information or its use for any purpose other than those listed in the “Notice of Privacy Practices” and/or consent requires your specific written authorization. If you change your mind after authorizing a use or disclosure of information that occurred before you notified us of your decision, you have the right to request restrictions on use or disclosure of your health information.

I authorize the person(s) listed below to receive all health information about appointments, treatment, and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Pineville Pediatrics.

Name of person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

**Acknowledgment of Review of Notice of Privacy Practices**

I have reviewed this office’s Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient or Representative (PRINT) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_