HIPAA Disclosure Form

Patient's Name: ______________________________________ **DOB:** ________________________

Receipt of Privacy Practices:

Protecting your child/children's privacy and medical information is at the core of our practice. We recognize our obligation to keep your information secure and confidential whether in written, oral or electronic format.

I have been provided with a Notice of Privacy Practices that provides a description of the uses and disclosures of my child/children's personal health information.

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Parent/Guardian Signature **Printed Name** **Date**

Medical Information Disclosure:

❑ I authorize Eureka Pediatrics to call the primary phone number listed below and leave a message regarding appointment reminders, insurance items, and my child/children's clinical care, including lab and imaging results. _________ **Initial**

❑ I authorize Eureka Pediatrics to use and or disclose pertinent health information about my child/children for school, camp or sport forms and securely fax such information as requested by school or a parent/guardian. _________ **Initial**

The phone number provided below is the best number for Eureka Pediatrics to contact me and will be listed as the primary number on my child/children's account.

Primary Phone Number: _____________________________ **❑Home ❑Mom Cell ❑Dad Cell**

Medical/Consent Information:

I authorize Eureka Pediatrics, its physicians and staff, to share any and all medical information with the following individuals. The individuals listed below are involved in my child's care and have authorization to talk to our staff on the phone and bring my child into the office. The individuals also have my consent to bring my child for immunization and any other medical treatment that may be needed during the office visit if I am able to be present. ***Both parents will automatically have authorization unless court document are presented specifically stating one is not authorized.***

❑ At this time I do not want to authorize anyone other than parent/guardian.

Name:_______________________________________ **Relationship to Patient:**____________________________
Name:_______________________________________ **Relationship to Patient:**____________________________
Name:_______________________________________ **Relationship to Patient:**____________________________

I understand that authorization to anyone other than myself is voluntary and I can revoke authorization at any time.

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Parent/ Guardian Signature **Printed Name** **Date**