The Pediatric Group HIPAA Form and Payment Waivers

Privacy Notice:

The HIPAA (Health Insurance Portability and Accountability Act) is a federal law that took final form and went into effect in April 2003. It is intended to protect the privacy of the medical information in the patient's record. It forbids health care providers from transmitting **any** information to **anyone** without written consent. This includes transmission of school forms, camp forms, vaccine dates or prescriptions to pharmacists. In order that we may continue to properly serve your child's medical needs, we ask that you select one of the following options;

1. to send in a signed consent by postal service or by fax with every request

   or

2. to sign a general consent that allows us to honor your request without a written signature for each individual request. This general consent does not apply to insurance companies, lawyers, research studies or marketing studies.

Either consent can be revoked, restricted or amended at any time by you.

HIPAA Waiver

I hereby authorize any agent of The Pediatric Group, P.A. to make appointments at TPGPA or with consultants to whom they may make referrals or from whom they may request consultation for me or for the minor for who I am the responsible or authorized party. Furthermore, I authorize any agent of TPGPA to examine, diagnose and treat, to perform laboratory test, diagnostic test, to administer medications and immunizations, to write, fax, telephone or electronically transmit prescriptions, and to disclose information as necessary to me, my designate and medical, educational, or ancillary medical consultants on behalf of the patient named herein to carry out payment or when TPGPA believes such action is in the best interest of the patient.

I have been given the opportunity to review the Privacy Notice of TPGPA. I understand that I may revoke or amend this authorization at any time or request to restrict the disclosure of personal health or financial information as set forth herein.

Patient Name______________________________

Signature of patient (or if under 18 parent or guardian must sign)______________________

Date:____________________

Please check box (optional):

☐ I give my parents access to my medical records.

Payment Waiver:

I agree to be financially responsible for all allowed charges not paid by my insurance company. I also state that I am aware that there is a fee associated with having blood draw in house at the Pediatric Group and know that any fee must be paid up front and can not be submitted to my insurance.

Patient Name______________________________

Signature of patient (or if under 18 parent or guardian must sign)______________________

Date:____________________