HIPAA Form

This consent form allows Thrive Pediatrics to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

Thrive Pediatrics has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at Thrive Pediatrics.

_____ I hereby authorize that Thrive Pediatrics may leave messages on my voicemail to confirm initial appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments.

___ cell phone ___ home phone ___work phone

_____ I hereby authorize that Thrive Pediatrics may send Text/SMS messages to my cell phone to confirm appointments.

_____ I hereby authorize that Thrive Pediatrics may leave messages on my voicemail regarding lab results and other office communications.

___ cell phone ___ home phone ___work phone

_____ I hereby authorize that Thrive Pediatrics may send Text/SMS messages to my cell phone regarding lab results and other office communications.

_____ I hereby authorize that Thrive Pediatrics may disclose my health information to any person(s) who accompany me to my appointment and are present with me in the clinic while I meet with my healthcare provider(s).

_____ I hereby authorize that Thrive Pediatrics may disclose my personal health information to the person who I have listed as my emergency contact.

_____ I hereby authorize that Thrive Pediatrics may disclose my personal health information to the initial following person(s):

Name	Telephone Number	Relationship to Patient

I understand that at any time I have the right to revoke this consent and must do so in writing, but that Thrive Pediatrics may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that Thrive Pediatrics may refuse service if I revoke this consent.

I understand that I have the right to request – now and in the future – how protected health information is used or disclosed to carryout treatment, payment and health care operations, and must be provided by me in writing. I understand that while Thrive Pediatrics is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

I understand that Thrive Pediatrics may refuse me services if I refuse to sign this consent.

By my signature below, I affirm the above information.

Signature of Parent /Authorized Representative_____ **Date**_____

Patient Name _____ **Date of Birth**_____