CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

PATIENTS 18 YEARS AND OLDER

This office is required by federal regulations to inform our patients in regards to the use of your child's health information in accordance to Health Insurance Portability & Accountability Act of 1996 or HIPAA

I understand that as part of my health care, Noah's Ark Pediatrics originates and maintains electronic records describing my health history, symptoms, examination and test results, diagnoses, treatments and any plans for future care or treatment.

I understand that as of my 18th birthday, I am considered an adult. Therefore, I need to give written consent to discuss my medical information with anyone other than myself including my parents.

By signing this form I am designating the parties below with whom I wish Noah's Ark Pediatrics to be able to discuss my medical information with. I understand that it is my responsibility to inform Noah's Ark Pediatrics in writing of any changes pertaining to this release.

I, __________________________ hereby authorize Noah's Ark Pediatrics to discuss with and release my medical information to the individuals below. This release is written without restriction and includes information relating to mental health.

Name: _____________________________ Relationship to patient _______________

Name: _____________________________ Relationship to patient _______________

Name: _____________________________ Relationship to patient _______________

I understand that as part of this organization's treatment, payment or healthcare operations it may become necessary to disclose my protected health information to another entity. I hereby consent to such disclosure for these permitted uses.

I fully understand and accept the terms of this consent.

________________________ ______________________
Signature Date

Patient contact # ___________________ (best number to reach you, i.e. cell phone)