Sacramento Pediatrics Medical Corporation

Consent for Release of Medical Information

Patient Name: _____ Date of Birth: _____
Address: _____
Phone Number: _____ Treatment dates from: _____to_____

I authorize: (enter previous provider information)

_____

_____

_____

To release copies of my medical records to: (enter new provider information)
Sacramento Pediatrics Medical Corporation
7501 Hospital Drive Suite 208
Sacramento CA 95823
Phone: 916-682-7841
Fax: 916-682-0423

I authorize release of information of the following portions of my medical records:

☐ All
☐ Immunization Records
☐ Labs
☐ Mental Health
☐ Communicable Disease
☐ Only the following: _____

I understand that this information shall be in effect for 180 days following the date of signature. However, I understand that this authorization may be revoked at any time giving oral or written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization. I understand that once my records have been released, the medical office cannot retrieve them and has no control over the use of the already released copies.

I hereby release _____ from any and all liability which may arise as a result of my authorized release of records.

Should my case require review by a governing agency or another medical profession actively involved in my care to make a final determination, it is my consent that a copy of these records will be submitted to the agency or medical profession for this review.

Patient (or legal representative) _____ Date: _____
Relationship to Patient: _____

Sacramento Pediatrics Medical Corporation

Protected Health Information (PHI) / HIPAA

Patient Name (Print) **Date**

Due to recent implemented Federal Regulations the following public notice by Sacramento Pediatrics is effective as of November 1, 2011.

The Sacramento Pediatrics is required to:

1. Maintain the privacy of your health information.
2. Provide you with this notice as to what our legal duties and privacy practices are with respect to information we collect aTest, Testnd maintain about you.
3. Abide by the terms of this practice.
4. Notify you if we are unable to agree to a requested restriction, and accommodate any reasonable request you may have to communicate health alternative means or alternative locations.
5. We will not use or disclose your health information without your authorization, except as described in this notice.
6. We will use and disclose your PHI in order to bill and collect payment for the services and items you may have received from us. For example, we will contact your insurer to certify that you are eligible for benefits and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment.

WE ARE PERMITTED TO USE, AND MAY BE REQUIRED, TO DISCLOSE YOUR PHI UNDER SPECIAL CIRCUSTANCES:

1. **Disclose Required By Law**: Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law, including health oversight activities, court or administrative orders or similar legal proceedings.
2. **Public Health Risk:** Our practice may disclose your PHI to public health authorities who are authorized to collect information for such purposes as maintaining vital records, preventing or controlling disease, injury, or disability; or notifying a person regarding potential exposure to a communicable disease.
3. **Serious Threats to Health of Safety**: Our practice may disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.
4. **Deceased Patients:** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
5. **Organ Donor:** Our practice may release PHI to a medical facility for tissue procurement of transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
6. **Worker's Compensation:** Our practice may release your PHI for workers' compensation and

similar programs.

Our practice may contact you or your authorized representatives (see authorization form attached) to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The practice might routinely contact patients via telephone at home and /or work, via mail at home, and unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appointments and billing questions.

All requests for medical records should be hand written and should contain:

Full Name

Date of Birth

Mailing Address

Phone Number

Written Signature

An additional fee might be asked for generating a copy or mailing all medical records as per the rules practiced by the clinic.

At no time will any person, including your spouse, be able to obtain information from your medical record without prior written authorization. Only parents or legal guardian of a child under the age of 18 will be allowed to access medical record information, with proof of child's social security number and date of birth.

Patient Rights

1. **Confidential Communications:** You have the right to request that our practice communicate with you about health and related issues in a particular manner or at a certain location. Our practice will accommodate reasonable request.
2. **Requesting Restrictions**: You have the right to request restriction on our use of disclosure of you PHI for treatment, payment, or health care operations. We are not required to agree to your request; however if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. **Inspection and Copies:** You have the right to request and obtain a copy of your PHI. Our practice will charge a fee for the cost of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy limited circumstances. However, you may request a review of our denial.
4. **Amendment:** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for this practice. Your request must provide us with the reason that supports your request for amendment. Your request may be denied if you ask us to amend information that is in our opinion: a) accurate and complete; b) not part of the PHI kept by or for the practice; c) not part of the PHI that you would be permitted to inspect and copy; or d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Rights to a paper Copy of This Notice:** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time.
6. **Rights to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

If you have any questions regarding this notice or would like to exercise any of your rights under this notice, you may contact:

Sacramento Pediatrics
7501 Hospital Dr. suite 208
Sacramento CA95823

Phone 916-682-7841

Sacramento Pediatrics

****Complete and return to Receptionist****

ACKNOWLEDGEMENT

I acknowledge that I have received the Notice of Privacy Practices from Sacramento Pediatrics and understand that if I have questions regarding this Notice I may contact the office at 7501 Hospital Dr. suite 208, CA 95823 916-682-7841.

Indicated below are names of any Person(s) to whom I would like Sacramento Pediatrics to allow disclosure of Individually Identifiable Health Information (IIHI). (Please, specify the type of information that may be disclosed, such as lab test, appointment information, prescription information, etc. You may indicate "All" if appropriate).

Name	Relation to Patient	Allowed Disclosure

Patient Name :