Rankin Children's Group, PLLC
HIPAA

Patient Consent for Use and Disclosure of Protected Health Information

HIPAA legislation grants patients several rights, among them greater access to and control over their medical records. This form is in effort to protect your information as well as protect our clinic from possible HIPAA violations.

I understand that as part of my child/children('s) health care, Rankin Children's Group, PLLC, which will be from this point forward referred to as RCG, originates and maintains paper and/or electronic records describing my child/children('s) health history, symptoms, examinations, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my child/children('s) care and treatment.
- A means of communication among the many health professionals who contribute to care.
- A source of information for applying the diagnosis and surgical information to my bill.
- A means by which a third-party payer (insurance company) can verify that services billed were actually provided.
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that RCG is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat my child as permitted by *Section 164,506 of the Code of Federal Regulations*.

I further understand that RCG reserves the right to change their notice and practices and prior to implementation, in accordance with *Section 164,520 of the Code of Federal Regulations*. Should RCG change their notice, they will provide me a copy of any revised notice upon my next visit.

The following people have access to my child/children('s) record, in addition to the mother and father of the child, unless their parental rights have been legally revoked:

** **In addition to the mother and father of the child, the following people may make and appointment or bring my child in for any appointment scheduled.**

_____

_____

I understand that the above listed names have full access to my child/children('s) record including billing information and account balance. I understand that RCG will verify to the best of their ability the identity of the listed people. I also understand that RCG may refuse to disclose any information if their identity is in doubt.

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

Patient's Name:	DOB:
Patient's Name:	DOB:
Patient's Name:	DOB:
Patient's Name:	DOB:
Patient's Name:	DOB:

Parent's Signature: _____ Date: _____