Authorization to Communicate with a Personal Representative

Under the requirements for HIPAA we are not allowed to give patient medical or financial information to anyone without the patient's consent. If you wish to allow us to release medical information or financial information with anyone you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent

I give Rose Pediatrics permission to contact me regarding test results, appointments, and other information regarding my medical care and or account information by:

- Email/Patient Portal communication
- Mail
- Phone

I give permission to Rose Pediatrics to leave a message on my answering machine or with the following person:

_____ _____

Personal Representative Name / Phone number Relationship

I give permission for my appointments to be arranged by:

_____ _____

Personal Representative Name / Phone number Relationship

_____ _____

Personal Representative Name / Phone number Relationship

_____ _____

Personal Representative Name / Phone number Relationship

Disclosure of Account information

I give Rose Pediatrics permission to disclose financial account information including billing details to:

☐ No One

☐ The following Patient Representative:

_____ _____

Personal Representative Name / Phone number Relationship

Disclosure of Medical information

I understand that giving a personal representative access to my medical information will give them access to my personal health information (PHI). I give Rose Pediatrics permission to disclose medical information to:

☐ No One

☐ The following Patient Representative can have access to:

- ☐ All records
- ☐ Records with the exception of the following:

Please circle:

Include or Exclude:	My health information related to Mental Health
Include or Exclude:	My health information related to Family Planning (Birth control, STI Screening, including HIV/AIDS)
Include or Exclude:	My health information related to Alcohol and Drug Abuse

_____ _____

Personal Representative Name / Phone number Relationship

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge receipt of a Notice of Privacy Practices from Rose Pediatrics.

I understand that Rose Pediatrics may, at its discretion, change the terms and conditions of this Notice. I understand the content of the Notice of Privacy Practices and that I will be provided a copy upon my request.

_____ _____

Patient Signature/Parent or Guardian Signature Date

The above authorizations will remain in effect until revoked by me in writing. A photocopy of this shall be considered as effective and valid as the original.