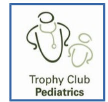


## Patient Information

**Last Name**_______________________ **First Name**____________________ **MI**_________________

**DOB** _____________________________ **Sex:** ☐ **Male** ☐ **Female** **SSN**_________________

Address______________________________________________________________________

APT # _______________________ **City**__________________________ **State**____ **Zip**__________

**Home Phone**_____________________ **Cell Phone**_____________________ **Work Phone**___________

**Email Address**__________________________________

**Messages regarding my visit today, including test results, may be left on** ☐ Home Phone ☐ Cell Phone

**Race:** ☐ White ☐ Black ☐ Hispanic ☐ Other _________________________________

**Ethnicity:** ☐ Hispanic ☐ Non-Hispanic

**Preferred Language:** ☐ English ☐ Spanish ☐ Other______________________________

**Mother's Name**_______________________ Phone______________ Address __________________________

**Father's Name:**__________________________ Phone ______________ Address___________________________

**Emergency Contact:**____________________________________________Phone_______________________

### Responsible Party/Guarantor

Last Name_____________________ First Name__________________ MI___ DOB ________________

Address______________________ City________________________ State____ Zip______________

Home Phone___________________ SSN__________________ Relationship to Patient_____________

### Insurance Information

**Primary Insurance Company** _______________**Policy Number**_____________ **Group Number**______________

**Address**__________________________ **City**___________________________ **State**_____ **Zip**________________

**Name of Insured**______________________ **DOB**____________________ **Relationship to Patient**______________

**Secondary Insurance Company** _______________**Policy Number**_____________ **Group Number**______________

**Address**__________________________ **City**___________________________ **State**_____ **Zip**________________

**Name of Insured**______________________ **DOB**____________________ **Relationship to Patient**______________

**Verification of Information**: I verify that the above information provided is true and correct to the best of my knowledge. I hereby authorize the facility to accept assignment of insurance benefits and I understand that I am responsible for coinsurance, copayments, and/or deductibles at the time of service< I understand that if my insurance is a non-contracted plan (out of network); the facility will courtesy file the claim for services rendered. In the event that I have no insurance coverage, I understand that the fees are due at the time of service. I understand that the facility has the right to withhold discharge paperwork and prescriptions in the event of nonpayment. I understand that the previous balances owed the facility will be requested at the time of registration.

X_______________________________________________________ X____________________

Authorized Signature of Patient/ Guardian/ Accompanying Adult Date

# Trophy Club Pediatrics Consent

**Patient's Name:_____________________________________Date of Birth:__________________________**

**Please initial and sign policies acknowledging your receipt and understanding of them.**

Initials

**______Notice of Privacy Policies (HIPPA Policy)**

**______Clinic Office Policies**

**______Assignment of benefits**

**______Patient Rights and Responsibility**

**______Consent to send you appointment reminders & links to register for patient portal via text messages and emails.**

**______Consent to obtain medication history from pharmacy**

**_____ CELL PHONES** • **Please turn off your cell phone**, in order to eliminate distractions when the doctor/nurse is with you. • ***Please note that Texting or Email doctors regarding your health issues is considered HIPPA violation*** so do not use these means to reach your doctor but instead schedule an appointment to discuss your concerns.

**_____ COPAYS and PAYMENTS** • ***We collect previous balances, co-pays, deductibles, co-insurance for every doctor's visit prior to being seen.*** If you have any questions regarding this, please call your insurance company. We don't know how your insurance applies this clause. We are a third party; the insurance company restricts our knowledge about what is and what is not covered under your signed plan. • Forms of payment accepted are Cash, Visa, & Master-card only! We do not accept checks, American Express or Discover cards. If you have a balance due and do not respond to our statements, we will charge your account for the balance due with the credit card information we have on file for you. When your delinquent account is submitted to a collection agency, a collection fee of 19% will be charged by the agency, and that will be added to your balance.

**_____ PHYSICAL EXAM (PE)** • If you are here for physical exam and want to be seen for other health issues (including sports physical) in addition to the PE or If during the PE, the doctor diagnoses other health conditions that require treatment, then we will bill your insurance for both sick and well visit. Your insurance might not pay for the combination visit; if this is the case then you are responsible in paying the complete balance due.

**_____ PRESCRIPTIONS** • Our doctor/PA/NP MUST SEE YOU prior to prescribing a new RX, refills on Antibiotics or Narcotics (Controlled medications) and changing your existing medication. • If you have not been seen the doctor within the past 3 months and need a refill, you must schedule an appointment to see doctor for your prescription refill, even if you are feeling fine. If you are out of town and need refill on your regular Rx then we will send 30 days supply only if you were seen in the last 3 months otherwise please see a physician for your emergencies. •

**_____ REFERRALS** • Obtaining a referral from your insurance can take up to 48 hours or more. ***Please do not call from the specialist's office at the time of your appointment for a referral***. Please call our office and schedule an appointment to get a referral before seeing a specialist.

**_____ NO SHOWS** • If you do not show up and/or do not call us 24 hours in advance to cancel or re-schedule your appointment, ***we reserve the right to charge a $25.00 fee*** for the scheduled time that we were unable to give to other patients. • After three consecutive no shows, we reserve the right to discharge you as our patient.

_____ A**THENACAPTURE** The athenaCapture mobile app and its supporting athenaNet workflows provide a simple, secure way for our clinic to add image documentation into athenaNet via smartphone or tablet device. Images pass directly from the point of capture — athenaCapture — to athenaNet, and are never stored unsecured, e.g., in a device camera roll, a memory card inserted into a camera, etc., without manual intermediate steps.

________________________________________________________________________________________

Patient/Patient's representative signature                                        Date

## Patient Rights and Responsibility

1. You will be provided a copy of the "Patient Rights and Responsibilities" prior to the procedure
2. You have the right to be free from discrimination based on age, race, ethnicity, religion, culture, language, physical or mental, disability, socioeconomic status, sex, sexual orientation and gender identity or expression
3. You have the right to a reasonable response to your request and need for treatment or service, within the hospital's capacity, its stated mission, and applicable laws and regulations.
4. You have the right to be informed about which physicians, nurses and other health care professionals are responsible for your care.
5. You have the right to change providers if you choose so. Patients are informed of the credentials of all staff who will be providing care during patient's stay
6. You, or your legal authorized representative, have the right to the information necessary for you to make informed decisions, in consultation with your physician, about your medical care including information about your diagnosis, the proposed care and your prognosis in terms and a manner that you can understand before the start of your care. You also have the right to take part in developing and carrying out your plan of care.
7. You have the right to consent to or refuse medical care, to the extent permitted by law, and to be told of the risks of not having the treatment and other treatments which may be available.
8. You have the right to reasonable access to care.
9. You have the right to care that is considerate and respectful of your personal values and beliefs. The hospital strives to be considerate of the ethnic, cultural, psychosocial, and spiritual needs of each patient and family.
10. You have the right to have a family member or representative of your choice and your own physician notified promptly of your admission to the Hospital.
11. You have the right to have your family take part in your care decisions with your permission.
12. You have the right, to the extent permitted by law, to have your legal guardian, next of kin, or a surrogate decision maker appointed to make medical decisions on your behalf in the event you become unable to understand a proposed treatment or procedure, are unable to express your wishes regarding your care, or you are a minor. The person appointed has the right, to the extent permitted by law, to exercise your rights as a patient on your behalf.
13. You and your appointed representative have the right to take part in ethical questions that arise during your care.
14. You have the right to communicate with family, friends and others while you are a patient in the hospital unless restrictions are needed for therapeutic effectiveness.
15. You and your legal representative have the right to access the information contained in your medical record in a timely manner subject to state and federal law.
16. You may request an explanation of your clinic bill, even if you will not be paying for your care.
17. You have the right to issue advance directives and to have doctors at the clinic and clinic staff follow your directives in accordance with state and federal law. However due to the clinic's limited capabilities, in the event of an emergency, the patient will be transferred to the nearest emergency room/hospital. The hospital or ER will be informed of the existence of the Advance Directives and such will be provided if the clinic has copies.
18. You have the right to personal privacy and for your medical information to be kept confidential within the limits of the law.
19. You have the right to receive care in a safe setting.
20. You have the right to be free from abuse or harassment.
21. You have the right to be free from restraints that are not medically necessary; restraints include physical restraints and medications.

PATIENT/RESPONSIBLE PARTY INITIAL:___________________

22. You have the right to be free from seclusion and restraints for behavior management except in emergencies as needed for your safety when less restrictive means may have been ineffective.
23. You have the right to consent or refuse to take part in any human research or other educational project affecting your care. You also have the right to be given information about the expected benefits and risks of any research you choose to take part in and any alternative treatment that might benefit you. Refusing to take part in the research or project will in no way affect your care.
24. You have the right to have your pain assessed and managed properly and to receive information about pain and pain relief measures.
25. You have the right to obtain information concerning the relationship of the clinic to other health care facilities as they relate to your care.
26. You have the right to submit a complaint to the clinic regarding your care. Your care will not be affected by submitting a complaint. Report any complaints to Clinic Manager.
27. You have a right to request and/or be provided language assistance i.e. Interpreter services, if you have a language barrier or hearing impairment. This will be provided at no cost to you to help you actively participate in your care

Patient's Responsibility

1. Provide accurate and complete information about your health, medications, allergies (including latex), current address, phone number, emergency contacts, and health insurance coverage and report changes in his/her condition or perceived risks in care
2. Ask questions when he/she does not understand what he/she has been told about care or what he/she is expected to do
3. Follow the prescribed treatment plan and report to the physician any side effects. Keep follow-up appointments to ensure good health care. If the patient refuses treatment or fails to follow the directions of his/her physician or proper hospital personnel, he/she will be responsible for his/her actions
4. Assure that the financial obligations of his/her healthcare are fulfilled, this includes co-payments, co-insurances, deductibles or for non-covered services at the time of the visit unless other arrangements have been made in advance with the Clinic Manager.
5. Follow the clinic's rules and regulations and be considerate of the rights of others at the hospital, such as assisting in the control of noise, smoking and number of visitors
6. Give at least 24 hours' notice to cancel any appointment.
7. Arrive 15 minutes prior to your appointment time.
8. Respect the rights of other patients and staff. Follow all Texas State rules and regulations pertaining to safety, smoking, and general conduct.
9. Ask questions regarding your diagnosis or treatment.
10. Plan ahead and be aware of the Trophy Club Pediatrics operating schedule because the TCP closes during certain holidays or times of the year.
11. Give prior notice to the TCP when translator services are needed for your care.
12. Pay for services when rendered, including financial responsibility for any charges not covered by insurance.
13. Notifying their health care provider of patient's Advance Directives, Living wills, Medical Power of Attorney or any other directives that could affect their care
14. Inform the Trophy Club Pediatrics of any concerns or complaints.
15. Refrain from using your cell phone during patient care.
16. The patient or family may voice concerns or complaints without having care affected in any way. They may discuss their concern with their doctor, nurse or other caregiver. If concerns are not resolved, they

PATIENT OR RESPONSIBLE PARTY INITIAL:_______________

should contact the Clinic Manager at 1-817-400-1572. If preferred, the patient/caregiver may contact the Texas Department of State Health Services Health Facility Compliance Division, PO Box 149347 Mail Code: 1979 Austin, Texas 78714 or their Ombudsman at 800-MEDICARE or www.cms.hhs.gov/center/ombudsman

PATIENT OR RESPONSIBLE PARTY SIGNATURE:______________________________

DATE:__________________________________________________________________

**Notice of Privacy Practices**
As Required by the Privacy Regulations Created as a Result of the
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**Who Presents this Notice**
This notice describes the privacy practices of Trophy Club Pediatrics PA d/b/a Trophy Club Pediatrics (the "Center") and members of its workforce, as well as the physician members of medical staff and allied health professionals who practice at the Center. The Center and the individual health care providers together are sometimes called "the Center and Health Professionals" in this notice.

**Privacy Obligations**
The Center and Health Professionals each are required by law to maintain the privacy of your health information ("Protected Health Information" or "PHI") and to provide you with this notice of legal duties and privacy practices with respect to your Protected Health Information. The center and Health Professionals use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. When the Center and Health Professionals use or disclose your "PHI", the Center and Health Professionals are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure). Your health information is contained in a medical record that is the physical property of Trophy Club Pediatrics.

**How We May Use and Disclose Medical Information About You**

**For Treatment:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or others who need to know about you to provide quality patient care. This information may be disclosed through information we record in your medical record or verbally between health care providers. We will also provide other medical facilities with information about you and your diagnoses which they will need in order to treat you. For example a doctor treating you for a broken arm may need to know if you have diabetes, because if you do, it may impact your recovery.

**For Payment:** We may use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company or a third party. For example, we may need to give your insurance company information about a procedure we performed so we can be paid for the office visit.

**For Health Care Operations:** We may use and disclose medical information about you for operational purposes. For example, your health information may be disclosed to members of our staff, risk or quality improvement personnel, and others to evaluate the performance of our staff, assess the quality of care, learn how to improve our office and services.

**Appointments.** We may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Disclosure to Relatives, Close Friends and Other Caregiver.** Your PHI may be disclosed to a family member, other relative, a close personal friend or any other person identified by you who is involved in your health care or helps pay for your care. If you are not present, or the opportunity to agree or object to a use or disclosure cannot be practicably be provided because of your incapacity or an emergency circumstance, the Center and/or Health Professionals would disclose only information believed to be directly relevant to the person's involvement with your health care or payment

related to your health care. Your PHI also may be disclosed in order to notify (or assist in notifying) such persons of your location or general condition.

**Special Situations in Which Your Information May be Released (including in response to Federal State or Local Law)**
- for judicial administrative proceedings pursuant to legal authority;
- to report information related to victims of abuse, neglect or domestic violence and to assist law enforcement officials in their law enforcement duties;
- if necessary to reduce or prevent a serious threat to your health or safety or the health or safety of another person or the public.
- in response to appropriate military authorities if you are a member of the military (including veterans)

**Local Public Health Authorities**
- in reporting child or elder abuse and neglect
- in reporting communicable diseases or your potential exposure to such
- in notifying you of recalls of drugs, products or devices you may be using

**Deceased Patients**
- to a medical examiner or coroner to assist in identifying the cause of death
- to allow funeral directors to do their jobs.

**Organ/Tissue donation.** Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

**Workers' Compensation.** Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.

**Research.** Your PHI may be used or disclosed without your consent or authorization if an institutional Review Board approves a waiver of authorization for disclosure

**As required by law**. Your PHI may be used and disclosed when required to do so by any other law not already referred to in the preceding categories; such as required by the FDA, to monitor the safety of medical device,
Fundraising. Your PHI may be used to contact you as a part of fundraising efforts, unless you elect not to receive this type of information.

Electronic Health Information Exchange. Trophy Club Pediatrics participates in an electronic health information exchange. The exchange allows Trophy Club to share health information with other providers and to receive health information from other providers so that you can get better care. You have the right to ask Trophy Club Pediatrics not to share your information through the exchange

**We Will Always Get Your Written Authorization Before Releasing or Using Your Information:**
- for marketing purposes
- in a manner that would constitute the sale of your protected health information
- in a manner not described in this notice and where required by either Federal or State Law.

**Your Health Information Rights**
You have a right to:
- Request a restriction on certain uses and disclosures of your information as provided by *45 CFR §164.522.* This may include a limit on medical information we disclose about you to someone who is involved in your care or payment for your care, such as a family member or friend. We are, however, not required to agree to a requested restriction except in cases where you have paid your bill in full and requested a restriction on releasing your information to a group health plan, insurer, or other payor for purposes of payment or health

care operations. You may request a restriction by completing a form developed by the office, or you can send a written request to the Health Information Services Department of Marietta Memorial Hospital.

- Obtain a paper copy of this notice at any time from the front desk.
- Inspect and obtain a paper copy of your health record and obtain an electronic copy to the extent the office utilizes an electronic medical record. If you desire access to your records, please obtain a record request form from the Clinic and submit the completed form. If you request paper records, you will be charged in accordance with federal and state law. To the extent the request for records includes portions of records which are not in paper form (e.g., x-ray films, CDs), you will be charged the reasonable cost of the copies. You will also be charged for the postage costs, if you request that the copies be mailed to you. However you will not be charged for copies that are requested in order to make or complete an application for federal or state disability benefits program.
- Amend your health record as provided in *45 CFR §164.526.* To request a copy or to amend your information you must make your request in writing and submit the request to the front desk or office address.
- Request communications of your health information by alternative means or at alternative locations.
- Revoke special authorizations to use or disclose health information for certain purposes except to the extent that action has already been taken.
- Request an accounting of all disclosures of your health information when the disclosure has not been pursuant to treatment, payment, operations, or an authorization and, if your information is maintained in an electronic format, request an accounting of any disclosures dating back three years from the date of the request.
- Request a hard copy of your medical information; or an electronic copy in a format requested by you if such format is readily producible.
- Receive a written notification of any inappropriate release or use of your protected health information.

**Obligations of Trophy Club Pediatrics**

We are required to:

- Maintain the privacy of protected health information.
- Provide you with this notice of our legal duties and privacy practices with respect to your health information.
- Abide by the terms of this notice.
- Notify you of certain breaches or the inappropriate release or use of your information.
- Notify you if we are unable to agree to a requested restriction on how your information is to be used or disclosed.
- Accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations.
- Release the minimum amount of your information necessary to accomplish information related functions and de-identify your information to the extent practicable.
- Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

For further information or Complaints. If you desire further information about your privacy rights, are concerned that your privacy rights have been violated or disagree with a decision made about access to your PHI, you may contact the Center. You may also file written complaints with the Office for Civil Rights of the U.S. Department of Health and Human Services or online at http://www.hhs.gov/ocr/office/file/index.html. Upon request the Center will provide you with the correct address for the Office for Civil Rights of the U.S. Department of Health and Human Services. The Center and Health Professionals will not retaliate against you if you file a complaint with the Center or the Director.
Effective Date: This notice is effective on September 8, 2014

**Changes to This Notice**

We reserve the right to change our information practices and to make new provisions effective for all protected health information we maintain. At the end of this notice you will be asked to sign that you have received the notice and have had the opportunity to receive a copy. Your signature is requested to help us determine which version of the notice you have received. Revised notices will be posted in the office and in registration areas throughout Memorial Health System. A paper copy will be made available to you upon request.

If you have questions or complaints, please contact:

Trophy Club Pediatrics
ATTN Office Manager
2213 Martin Drive Suite 200
Bedford, TX 76021
Phone: 817-400-1571
Fax: 855 298 3967

ACKNOWLEDGMENT

| | |
|---|---|
| *Patient's Signature* | |
| *Authorized Representative's Signature* | |
| *Authorized Representative's Name* | |
| *Relationship of Authorized Representative* | |
| *Date and Time* | |
| *TCP Representative Signature* | |
| *TCP Representative Name* | |
| *Date and Time* | |

**TCP USE ONLY**

Reason acknowledgment was not obtained:

Trophy Club Pediatrics
Providing excellent medical care for your child

## Consent for Medical Treatment

I do hereby voluntarily consent to and authorize Trophy Club Pediatrics (TCP) to provide care which encompasses all diagnostic and therapeutic treatments, including HIV testing, considered necessary or advisable in the judgment of the attending physician or her/his designee. By signing this form, I do not waive my right to refuse recommended tests or treatments

**Acknowledgement of Use and Disclosure of Protected Health Information**

I Understand:

- Trophy Club Pediatrics personnel and my clinician will create and maintain a record of the care and services provided to me.
- Information relating to my treatment, payment or health care operations may be used or disclosed in the delivery and management of care and services provided by Trophy Club Pediatrics.
- I have received a copy of Trophy Club Pediatrics' Notice of Privacy which describes how my protected health information may be used or disclosed.
- I have received, read and understand the Patient Bill of Rights

**Preservation of Records:** Trophy Club Pediatrics may authorize disposal of medical records relating to the patient on or after the time periods specified in the Texas Health and Safety code.

**Valuables:** I understand that Trophy Club Pediatrics does not assume responsibility for the safekeeping of any personal property that I choose to keep on my person or in the clinic during my visit.

**Financial Responsibility and Assignment of Benefits.** In consideration for receiving medical or health care services, I hereby assign to TCP physicians and providers my right, title, and interest in all insurance, Medicare/Medicaid, or other third-party payer benefits for medical or health care services otherwise payable to me. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third-party payer, up to the total amount of my medical and health care charges, to TCP physicians I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct. I agree to pay all charges for medical and health care services not covered by, or which exceed, the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer, and agree to make payment as requested by TCP

**Length of Time Consent is in Effect:** The Consent to Treatment will be valid and remain in effect as long as the patient seeks health care in the TCP clinics, unless revoked by the patient in writing with written notice provided to clinic attended by the patient. Occasionally the form may be revised and will require a new signature

I have read and understand this form. The information has been explained to me to my satisfaction, I accept and agree to the items contained in this Consent to Medical Treatment.

| *Patient's Signature* | |
|---|---|
| *Authorized Representative's Signature* | |
| *Authorized Representative's Name* | |
| *Relationship of Authorized Representative* | |
| *Date and Time* | |
| *TCP Representative Signature* | |
| *TCP Representative Name* | |
| *Date and Time* | |

## REQUEST FOR RELEASE OF INFORMATION

**Information regarding patient for whom authorization is made:**

Full Name: ____________________________________________

Other Name(s) Used: ____________________ Date of Birth: ____________________

Address:____________________ City:____________ State:_____ Zip Code:______

Phone: (_____)____________________ Email (*Optional*): ____________________

**Information regarding health care provider or health care entity authorized to disclose this information:**

Name: ____________________________________________

Address:____________________City:____________ State:______ Zip Code:______

Phone: (_____)____________________ Fax: (_____)____________________

**Information regarding person or entity who can receive and use this information:**

Name: Trophy Club Pediatrics PA/ TCP

Address: 2213 Martin Drive, Suite 200. Bedford TX 76021

Phone: **817-400-1572** Fax 855 298 3967

**Specific information to be disclosed:**

□ Medical Record from (insert date) ______________ to (insert date) ______________

□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.

□ Other: ____________________________________________

**Include:** (***Indicate by Initialing***)

________ Drug, Alcohol or Substance Abuse Records

________ Mental Health Records (Except Psychotherapy Notes)

________ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)

________Genetic Information (Including Genetic Test Results)

**Reason for release of information:**

***(Choose all that Apply)***

□ Treatment/Continuing Medical Care

□ Personal Use □ School

□ Billing or Claims □ Employment

□ Insurance □ Disability Determination

□ Legal Purposes

□ Other*(Specify)*: ______________

**<u>The individual signing this form agrees and acknowledges as follows</u>:**

(I) **<u>Voluntary Authorization</u>:**This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **<u>Effective Time Period</u>:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: Month: ________ Day: ________ Year: _________.

(iii) **<u>Right to Revoke</u>:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **<u>Special Information</u>:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) **<u>Signature Authorization</u>:**I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

**SIGNATURES:**

Patient/Legal Representative: ________________________________________Date:________________

If Legal Representative, relationship to Patient________________________________________________

Witness (optional): _______________________________________________Date: ______________

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): _____________________________________ Date: ________________