Praful U. Bhatt, M.D.
Pediatrics and Adolescent Medicine
72 East Church Street, Lock Haven, PA 17745

HIPAA – NOTICE OF PRIVACY PRACTICES & RELEASE OF MEDICAL INFORMATION

HIPAA

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office or viewing it at www.drbhatt.net

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. Our practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- Our practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but our practice does not have to agree to those restrictions
- The patient may revoke this consent in writing at any time and all future disclosures will then cease
- Our practice may condition receipt of treatment upon the execution of this consent

APPROVAL TO RELEASE IMMUNIZATION INFORMATION

I give my permission to disclose/release proof of immunization to the school attended by this patient.

RELEASE OF MEDICAL INFORMATION **Date______________________**

I give my permission to release medical information to:

____

____

Patient Name: ____Date of Birth: _____________

Name/Signature of Parent or Legal Guardian: ____

Other siblings this applies to____

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HIPAA COMPLIANT REQUEST & AUTHORIZATION TO OBTAIN/RELEASE PROTECTED MEDICAL INFORMATION

____
Patient Name   Date of Birth   Phone Number

____
Address   City   State   Zip Code

I hereby give Praful U. Bhatt, M.D. permission to

____obtain my child's Protected Health Information (PHI) from or ____release/disclose PHI to

Facility / Physician / Person: ____

Address______ ____

City: ______________________ State: ________Zip ___________Phone_______________
(Full name & address must be completed to release or obtain records)

I authorize the specific records chosen below to be obtained/released from/to the entity listed above:

______Complete Record _____Immunization record, current and past problem list
______Summary of office visits with diagnoses ______Service from _______through _______

HIV, Behavioral Health, or Drug and Alcohol Abuse/Treatment information contained within the dates of service I have specified above *are to be released through this authorization unless specified below*:

DO NOT RELEASE: (check all that apply)
______Treatment of STDs (Sexually Transmitted Diseases) and/or HIV testing results
______Drug or alcohol abuse
______Psychiatric Problems

This authorization expires 6 months from the date of this signature, or at the following event _________________.
I am requesting my child's PHI to be disclosed for the following purpose:

______For a Second Opinion   ______Specialist visit
______Residence Moved ______Dissatisfied with Care Received
______Change in Insurance -Name of New Insurance Co.____________________

I may revoke this authorization at any time by mailing or personally delivering a signed written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this authorization. I am entitled to a copy of this authorization upon my request. I may not be required to sign this authorization as a condition to obtaining treatment or payment or my eligibility for benefits. **The recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may no longer be protected by law**. I am entitled to a notice, if my protected health information is used for marketing and results in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

____
Signature of Parent/Guardian   Relationship to Patient   Date

Record Transfer Fee $___________Payment Type _______________Date Paid___________________
Date Records Sent _________________Sent by ______________Physician Approval_______________