HOT SPRINGS PEDIATRIC CLINIC, P.A.

PATIENT INFORMATION

TODAY'S DATE_____

CHILD'S FULL NAME _____
(FIRST) (MIDDLE) (LAST)

FOR INSURANCE PURPOSES, CHILD'S NAME MUST BE AS IT APPEARS ON THE BIRTH CERTIFICATE

SOCIAL SECURITY #_____DATE OF BIRTH_____

WHAT TYPE OF INSURANCE DOES YOUR CHILD HAVE? NAME & ID # _____

(IF NEWBORN, LIST WHAT INSURANCE BABY WILL HAVE)_____

PHYSICAL ADDRESS_____
(STREET ADDRESS) (APT/UNIT #) (CITY) (STATE) (ZIP)

MAILING ADDRESS_____
(STREET ADDRESS) (APT/UNIT #) (CITY) (STATE) (ZIP)

PREFERRED CELL PHONE NUMBER (_____)_____-_____ PREFERRED HOME PHONE NUMBER (_____)_____-_____

PREFERRED METHOD FOR APPOINTMENT REMINDERS: ☐ CALL ☐ TEXT ☐ MOTHER / GUARDIAN-1 EMAIL ☐ FATHER / GUARDIAN-2 EMAIL

NAME OF SCHOOL/DAYCARE_____

RACE/ETHNICITY_____ MALE_____ FEMALE_____

RESPONSIBLE PARTY INFORMATION

MOTHER/GUARDIAN'S NAME_____
(FIRST) (MIDDLE) (LAST) (MAIDEN)

PHYSICAL ADDRESS_____
(STREET ADDRESS) (APT/UNIT #) (CITY) (STATE) (ZIP)

MAILING ADDRESS_____
(STREET ADDRESS) (APT/UNIT #) (CITY) (STATE) (ZIP)

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____

EMPLOYER/OCCUPATION _____ WORK PHONE NUMBER _____

DAYTIME PHONE NUMBER _____ NIGHTTIME PHONE NUMBER_____

EMAIL ADDRESS: _____ RACE/ETHNICITY_____

FATHER/GUARDIAN'S NAME _____
(FIRST) (MIDDLE) (LAST)

PHYSICAL ADDRESS _____
(STREET ADDRESS) (APT/UNIT #) (CITY) (STATE) (ZIP)

MAILING ADDRESS _____
(STREET ADDRESS) (APT/UNIT #) (CITY) (STATE) (ZIP)

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____

EMPLOYER/OCCUPATION _____ WORK PHONE NUMBER _____

DAYTIME PHONE NUMBER _____ NIGHTTIME PHONE NUMBER _____

EMAIL ADDRESS: _____ RACE/ETHNICITY_____

IN THE EVENT OF AN EMERGENCY, PLEASE LIST SOMEONE WE CAN CONTACT OTHER THAN YOURSELF

NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____
(STREET ADDRESS) (APT/UNIT #) (CITY) (STATE) (ZIP)

PRIMARY PHONE NUMBER _____ SECONDARY PHONE NUMBER _____

IS THIS PERSON AUTHORIZED TO BRING MINOR PATIENT IN FOR MEDICAL CARE, TREATMENT AND/OR ADMINISTRATION OF IMMUNIZATIONS? **YES** or **NO**

PREFERRED CHOICE OF PHARMACY: NAME_____**LOCATION**_____

SECONDARY CHOICE OF PHARMACY: NAME_____**LOCATION**_____

TURN OVER

HOT SPRINGS PEDIATRIC CLINIC, P.A.

PATIENT'S NAME_____ **DATE OF BIRTH**_____

OTHER IMPORTANT PHONE NUMBERS _____
(NAME) (PRIMARY PHONE NUMBER)

_____
(NAME) (PRIMARY PHONE NUMBER)

IS ANYONE, OTHER THAN THE PARENTS/GUARDIANS, AUTHORIZED TO BRING YOUR CHILD TO THIS OFFICE FOR MEDICAL CARE AND/OR THE ADMINISTRATION OF IMMUNIZATIONS? **YES** or **NO**
IF YES, PLEASE LIST THE NAME(S) AND RELATIONSHIP (S) TO THE PATIENT:

PLEASE LIST THE NAMES AND DATES OF BIRTH OF OTHER CHILDREN IN YOUR FAMILY:

IF YOUR CHILD (CHILDREN) COMES TO THE CLINIC WITH SOMEONE OTHER THAN THE PARENT/GURADIAN, THAT PERSON WILL BE EXPECTED TO SETTLE THE OFFICE VISIT COST AT THE TIME OF SERVICE.

ACKNOWLEDGEMENT OF CLINIC APPOINTMENT POLICY:

We require notification that a patient is unable to keep a scheduled appointment as soon as possible and a minimum notice of two (2) hours prior to the scheduled appointment time or the appointment will be counted as a No-Show. Two (2) No-Show appointments is considered excessive and cause for dismissal.

I UNDERSTAND THE ABOVE POLICY AND AGREE TO CONTACT THE CLINIC AS SOON AS POSSIBLE AND, AT THE MINIMUM, TWO HOURS PRIOR TO A SCHEDULED APPOINTMENT IF THE PATIENT IS UNABLE TO KEEP THE APPOINTMENT OR NEEDS TO RESCHEDULE.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN **DATE**

_____ _____
PRINTED NAME **RELATIONSHIP**

AUTHORIZATION AND RELEASE

* **I AUTHORIZE THE RELEASE AND/OR THE REQUEST OF ANY INFORMATION INCLUDING THE HISTORY, IMMUNIZATION RECORD, EXAMINATIONS, DIAGNOSIS, AND TREATMENT RENDERED TO MY CHILD TO THIRD PARTY PAYORS, OTHER HEALTH PRACTITIONERS, AND/OR PUBLIC OR PRIVATE SCHOOL IN WHICH MY CHILD ATTENDS OR HAS ATTENDED.**
* **I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DOCTOR OR DOCTORS'S GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.**
* **I UNDERSTAND THAT MY INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON BEHALF OF MY DEPENDENTS.**
* **I AGREE THAT A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL.**

_____ _____
SIGNATURE OF PARENT OR GUARDIAN **DATE**

_____ _____
PRINTED NAME **RELATIONSHIP**

JESSICA D. CANNON, DO, FAAP

SARAH B. HARDY, MD, FAAP

JULIA C. TOGAMI, MD, FAAP

KRISTIN SCHNEBLY DUNN, APRN

BROOKE N. FERGUSON, CPNP

BETSY A. EFIRD, APRN

Patient Name & DOB:_____

_____

Household Financial Policy

WELCOME: We are pleased that you have chosen Hot Springs Pediatric Clinic as your child's or children's pediatric clinic. We feel that we can better serve you if you are familiar with our policies and procedures.

BILLING: It is your responsibility to pay any deductible, co-payment or co-insurance at the time of service. Other balances left unpaid by your insurance company will be your responsibility (excluding any discounts from managed care or other contractual adjustments.) ALL COPAYS, COINSURANCE, DEDUCTIBLES & OUTSTANDING BALANCES ARE NOW DUE UPON ARRIVAL. Any labs or test performed during a visit will be due at checkout at the end of the appointment.

INSURANCE: Patients/Parents/Guardians must realize that professional services are rendered to a person not an insurance company. We will file all primary insurance, however, please furnish us with current insurance information. If we are not contracted with your primary insurance carrier, when called they may not give us the status of your claim. We will rely on you to settle the claim. Our goal is to assist you with verification of coverage. However, the information received verbally from your insurance company is not a guarantee of coverage or payment. The charges incurred at Hot Springs Pediatric Clinic are solely the responsibility of the Patient/Parents/Guardians. We will file secondary insurances, however, we require Patient/Parents/Guardians to provide us with CURRENT secondary insurance information. If any of your insurance information changes, it is your responsibility to notify us immediately of the changes.

SELF PAY: If you are not covered by an insurance company, it is your responsibility to settle your accounts in full at the time of service.

IF YOUR CHILD/ (CHILDREN) ATTEND THE CLINIC WITH SOMEONE OTHER THAN THE PARENT OR GUARDIAN, THAT PERSON WILL BE EXPECTED TO SETTLE THE CO-PAYMENT OR OFFICE VISIT COST AT THE TIME OF SERVICE.

Signature: _____ **Date:** _____

(Patient/Parent/Guardian)

JESSICA D. CANNON, DO, FAAP

JULIA C. TOGAMI, MD, FAAP

BROOKE N. FERGUSON, CPNP

SARAH B. HARDY, MD, FAAP

KRISTIN SCHNEBLY DUNN, APRN

BETSY A. EFIRD, APRN

HIPPA ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices

I, _____, am the parent or guardian of

(Parent/Guardian)

_____ _____

(Patient's Name) (Patient's DOB)

And have received a copy of Hot Springs Pediatric Clinic's Notice of Privacy Practices.

X_____

HOT SPRINGS PEDIATRIC CLINIC

CHILD'S NAME: _____ TODAY'S DATE: _____

DOB: _____

HISTORY OBTAINED FROM: _____

DATE: _____

FAMILY & SOCIAL HISTORY

Father's Age & Health: _____

Father's Height: _____

Occupation: _____ **Are you a smoker? Y or N**

Mother's Age & Health: _____

Mother's Height: _____

Occupation: _____ **Are you a smoker? Y or N**

Parent's Marital Status: _____

_____

Household Occupants: _____

_____

Pets: _____

_____

Daycare: _____

Child's Siblings		**Age**	**Health**
MALE	**FEMALE**	_____	_____
MALE	**FEMALE**	_____	_____
MALE	**FEMALE**	_____	_____
MALE	**FEMALE**	_____	_____
MALE	**FEMALE**	_____	_____
MALE	**FEMALE**	_____	_____

Mother's Family	**Age**	**Health**
Child's Grandfather	_____	_____
Child's Grandmother	_____	_____

Father's Family	**Age**	**Health**
Child's Grandfather	_____	_____
Child's Grandmother	_____	_____

OVER

CHILD'S NAME: _____

DOB: _____

Has any relative had any of the following? If so, list the relationship and details.

ALLERGIES _____

ANEMIA _____

ARTHRITIS _____

ASTHMA _____

BLEEDING PROBLEMS _____

DEAFNESS _____

DIABETES _____

CANCER _____

HEART ATTACK / DISEASE _____

HIGH BLOOD PRESSURE _____

STROKE _____

KIDNEY DISEASE _____

THYROID DISEASE _____

SICKLE CELL DISEASE _____

SEIZURES _____

IBS/ CROHN'S/ UC/ CELIAC _____

DEATH BY SUICIDE _____

EMOTIONAL PROBLEMS _____

BIRTH DEFECTS _____

LEARNING PROBLEMS _____

INFANT DEATHS _____

SUDDEN DEATH IN ADULTS _____

PAST MEDICAL HISTORY

CHILD'S NAME: _____ TODAY'S DATE: _____

DOB: _____

Place of Birth: _____

Pregnancy Complications: _____

Type of Delivery: **C-Section** _____ **Vaginal** _____

Gestation: **Full Term** _____ **Early** _____ **Birth Weight** _____

Problems with pregnancy or delivery: _____

Hospitalizations: _____

Surgeries: _____

Other Significant Illnesses: _____

Injuries / Accidents: _____

Drug Allergies: _____

Other Allergies: _____

Concerns about development or school performance: _____

Immunizations: _____

Current Medications: _____

OVER

CHILD'S NAME: _____

DOB: _____

Please check any of the following problems that your child has had: If "YES" give brief details

JAUNDICE	_____	_____
ANEMIA	_____	_____
PREMATURITY	_____	_____
CONSTIPATION	_____	_____
MULTIPLE UTI'S	_____	_____
BEDWETTING	_____	_____
ASTHMA	_____	_____
ENVIRONMENTAL ALLERGIES	_____	_____
EAR INFECTIONS	_____	_____
PNEUMONIA	_____	_____
STREP THROAT	_____	_____
MENINGITIS	_____	_____
SCOLIOSIS	_____	_____
BONE OR JOINT PROBLEM	_____	_____
AUTISM	_____	_____
DEVELOPMENTAL DELAYS	_____	_____
ANXIETY/ DEPRESSION/ MOOD DISORDER	_____	_____
ADHD	_____	_____
SEIZURES	_____	_____
UNUSUAL HEADACHES	_____	_____
CROSSED OR LAZY EYE	_____	_____
WEARS GLASSES/ CONTACTS	_____	_____
PROBLEMS W/ HEARING	_____	_____

9, Military. Our group may disclose your Hill if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our group may **disclose your UHT** to federal officials for intelligence and national security activities authorized by law. We also may disclose your **IIHI** to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our group may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a)for the institution to provide health care services to you, (b)for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our group may release your Mil for workers' compensation and similar programs.

13. Other uses of medical Information. Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to *use* or disclose medical information about you, you may revoke that permission, in writing, at any time and we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

E. YOUR RIGHTS REGARDING YOUR IIHI You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our group communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Privacy Officer specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. 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. In order to request a restriction in our use or disclosure of your **IIHI,** you must make your request in writing to the Privacy Officer. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Privacy Officer in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may revest a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

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 our practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the **IIHI** which 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. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your MI for non-treatment, non-payment or non-operations purposes. Use of your **IIHI** as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. Also, we are not required to document disclosures made pursuant to an authorization signed by you. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer. All requests for an "accounting of disclosures" must state a time period, which may not be longer *than six (6) years* from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right 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. To obtain a paper copy of this notice, contact the Privacy Officer.

7.Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our group or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Privacy Officer. We urge you to file your complaint with us first and give us the opportunity to address your *concerns.* All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to Provide an Authorization for Other Uses and Disclosures. Our group will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact the Privacy Officer.

Hot Springs Pediatric Clinic, P.A.

NOTICE OF PRIVACY PRACTICES

Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY *BE* USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Effective: April 14, 2003
Revised: January 1, 2007

A. OUR COMMITMENT TO YOUR PRIVACY

Hot Springs Pediatric Clinic is dedicated to maintaining the privacy of your individually identifiable health information RHO. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our group concerning your III-11. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your MI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your EMI that are created or retained by our group. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our group has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our group will post a copy of our current Notice in our office in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Attn: Privacy Officer
1920 Malvern Ave.
Hot Springs, AR 71901

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI

1. Treatment. Our group may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your 1.11-1I in order to write a prescription for you, or we might disclose your III-11 to a pharmacy when we order a prescription for you. Many of the people who work for our practice — including, but not limited to, our doctors and nurses — may use or disclose your IIII1 in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.
Finally, we may also disclose your BHT to other health care providers for purposes related to your treatment.

2. Payment. Our group may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of 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 also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIIH to bill you directly for services and *items. We* may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our group may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIII1 to other health care providers and entities to assist in their health care operations.

4,- --Appointment Reminders. Our group-may-use and— . . disclose your 111-1.1 to contact you and remind you of an appointment.

5. Treatment Options. Our group may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our group may use and disclose your IIHI to inform you of health related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our group may release **your IIHI** to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter *may* have access to this child's medical information.

8. Disclosures Required By Law. Our group will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our group may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
  notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

L--Health -Oversight Activities. Our group may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures **or** actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3 Lawsuits and Similar Proceedings. Our group may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release 11H1 if asked to do so by a law enforcement official:

Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
Concerning a death we believe has resulted from criminal conduct
Regarding criminal conduct at our offices
In response to a warrant, summons, court order, subpoena or similar legal process
To identifyflocate a suspect, material witness, fugitive or missing person
In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our group may release **MN** 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.

6. Organ and Tissue Donation. Our group may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our group may use and disclose your all for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when Internal or Review /Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the follow-_ing:._(A) an adequate plan to protect the identifiers from improper use and disclosure; B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the 11111 will not be used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the IIHI.

8. Serious Threats to Health or Safety. Our group may use and disclose your IIHI 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. Under 1these circumstances, we will only make disclosures to a** iperson or organization **able** to help prevent the threat.

HOT SPRINGS PEDIATRIC CLINIC, P.A.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

I hereby authorize _____
(Name of Physician, Clinic, School, Entity or Individual)

_____
(Street Address)

Patient's last doctor

_____
(City State Zip)

PH# ( ) -

Fax# ( ) -

and its physicians employees and agents to release or disclose to the below-named recipient all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

Patient Name: _____ Date of Birth: _____

I hereby authorize the release of medical records to: HOT SPRINGS PEDIATRIC CLINIC, P.A.
1920 MALVERN AVE
HOT SPRINGS, AR 71901
OFFICE: (501) 321-1314

PLEASE MAIL RECORDS – DO NOT FAX (PRINTED, USB DRIVE,OR DISC ONLY)

Purpose of disclosure: _____

The authorization will expire on: _____
(Date or Event may not exceed one year)

This request and authorization applies to:

_____ All medical records

_____ Health care information relating to the following treatment, condition, or dates of treatment:

_____

_____

_____ Specific records to be released (eg. Labs, imaging reports, other):

_____

If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.

_____Substance abuse _____ Psychological or psychiatric treatment ____HIV/AIDS/STD

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

_____
Signature of Patient or Authorized Representative Date Signed

_____
Relationship to Patient