MOUNT MEEKER PEDIATRICS

Age 18+ HIPAA Consent

First Name: _____ Last Name: _____ DOB: _____

Communication Preferences:

- ☐ Phone Call: _____
- ☐ Email: _____
- ☐ Mail (add if different than home address): _____
- ☐ Text Message (phone #): _____

Appointments may be scheduled/changed by:

- ☐ Only me
- ☐ Mother (name): _____
- ☐ Father (name): _____
- ☐ Other (name & relationship): _____

Prescriptions may be picked up by:

- ☐ Only me
- ☐ Mother (name): _____
- ☐ Father (name): _____
- ☐ Other (name & relationship): _____

My medical and financial information may be accessed by:

- ☐ Only me
- ☐ Mother (name): _____
- ☐ Father (name): _____
- ☐ Other (name & relationship): _____

I authorize Mount Meeker Pediatrics to release the following information to the designated party above:

- ☐ FULL DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)
- ☐ LIMITED DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) (Excludes information regarding sexual activity, STD, HIV/AIDS, alcohol and/or drug use, psychological or psychiatric records)

- I understand Mount Meeker Pediatrics sends prescriptions to the pharmacy electronically (ePrescribe).
- I understand Mount Meeker Pediatrics sends appointment reminders and other notifications by text message to my listed cell # (standard text rates may apply).
- I understand if I choose to change any information above, I must provide written notice to Mount Meeker Pediatrics

I **acknowledge that I have read and understand the Mount Meeker Pediatrics Notice of Privacy Practices.**

_____

Signature Date

_____

Printed name