Avalon Park Pediatrics Notice of Privacy Practices

Consent to the Use and Disclosure of Personal Health Information for
Treatment, Payment, or Healthcare Operations

DISCLOSURE OF INFORMATION: As part of your health and medical care, Avalon Park Pediatrics originates and maintains medical and health records describing your health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. Avalon Park Pediatrics, including physician and staff may use and disclose your child's medical information for the following purposes:

TREATMENT: We may use your child's health information to provide, coordinate or manage medical treatment or related services.

PAYMENT: We may use and disclose health information to bill or collect payment for services rendered from either you or your insurance carrier. A full description of our billing agreement is provided and signed by all patient/guardians.

HEALTH CARE OPERATION: We may use your child's health information to coordinate medical care with other health care providers, as well as to obtain eligibility, benefits and payment on claims from your insurance carrier.

LEAVING MESSAGES: There are times when we cannot reach you and need to leave a message. We may use your or your child's information to contact you and leave messages on the provided phone numbers to confirm scheduled appointments or nurse follow-up calls regarding your child's health.

IMMUNIZATIONS: Immunization records are public records of the state and we may fax them to any childcare facility, or school who requests a copy.

INDIVIDUALS INVOLVED IN YOUR CHILD'S CARE: Please list all individuals, including spouse, step-parent and/or guardian that will have access to your child's information. We want to ensure protection of your child's medical information.

_____	_____	_____	_____
Name (Please Print)	Relationship	Name (Please Print)	Relationship
_____	_____	_____	_____
Name (Please Print)	Relationship	Name (Please Print)	Relationship

RESTRICTIONS: I request the following restrictions to the use and/or disclosure of my health information including any individuals I do not want information released to.

_____	_____	_____	_____
Name (Please Print)	Relationship	Name (Please Print)	Relationship

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_____

Other restrictions

By Oklahoma law we are required to notify you……. **That the information authorized for release may include records which may indicate the presence of communicable or venereal disease which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome(AIDS).**

I understand…..A copy of the complete description of how my medical information will be used and disclosed can be requested at any time. This agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement shall remain in force until revoked in writing by the patient/guardian.

_____	_____
Patient Name (Please Print)	Date Notice Effective
_____	_____
Signature of Patient or Legal Guardian	Relationship to Patient

(Office Use) Avalon Park Pediatrics conditionally ____accepts ____denies the restrictions listed above regarding release of information.

_____ _____

Signature/Title by Avalon Park Pediatrics Date