Mountain View Pediatrics

77 West Forest Avenue, Suite 304
Flagstaff, AZ 86001
(928) 214-3600

Patient Name: _____

Date of Birth: _____

Parent/Guardian Name: _____

Patient Consent for Use and Disclosure of Protected Health Information (HIPAA)

With my consent, Mountain View Pediatrics (MVP) may use and disclose my child's health information to carry out treatment, payment, share electronic medical records with other medical providers and health care operations. Please refer to our office's Notice of Privacy Practices for a more complete description of uses and disclosures. I have the right to review the Notice of Privacy Practices and the HIE (Health Information Exchange) prior to signing this consent. MVP reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Practices may be obtained by forwarding a written request to Mountain View Pediatrics Privacy Officer at 77 W. Forest, Suite 304, Flagstaff, AZ 86001.

With my consent Mountain View Pediatrics may:

- Call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in regards to my child's healthcare, such as appointment reminders, insurance items and any call pertaining to my child's clinical care, including laboratory results among others.
- Mail or fax to my home or other designated location any items that assist the practice with my child's healthcare, such as an appointment reminder calls and patient statements.
- E-mail, text message appointment reminders, patient statements and response to email I have sent concerning my child's health information.

I have the right to request in writing that MVP restrict how it uses or discloses my child's healthcare information to carry out treatment, payment, and healthcare operations. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to MVP to use and disclose my child's health information in order to provide treatment, seek payment from insurance companies, other third parties or myself and other items related to health care operations.

I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in The Network, the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, due to the restrictions on disclosure of healthcare information and its effect on the ability to perform diagnosis and treatment, MVP will be unable to provide treatment for my child.

_____

Patient's Name

_____

Print Name of Parent or Legal Guardian

_____ _____

Parent or Guardian Signature **Date**