AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION
JUST US KIDS PEDIATRICS
2462 HIGHWAY 34 EAST NEWNAN, GA 30265
PHONE: 770-683-5437

MEDICAL RECORDS ARE NOT ACCEPTED VIA FAX, PLEASE MAIL TO ABOVE ADDRESS

Patient Name: First__________________________ Last_________________________
Date of birth: _____________________ Phone:________________________
Address: ___________________________________ City: ________________________
State: ___________ Zip Code:________________
How did you hear about us? _________________ Insurance Company: ____________
Email Address (for E-bills & other important updates): ____________________________

1. I authorize representatives Just Us Kids Pediatrics to (release/request) my health information (to/from) the following (facility/person): (Please list past pediatrician info below)

Name: ____
Address: ____
City: _________________ State: __________ Zip Code: _____________
Phone: __________________________ Fax: ________________________

2. DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED:

[ ] Complete medical records (including IMMUNIZATIONS) [ ] Partial medical records
[ ] History & Physical [ ] Consultations [ ] Discharge Summary [ ] Lab Results [ ] Xray Reports

3. PURPOSE OF DISCLOSURE:

[ ] At my request [ ] Other:_______________________________________

4. EXPIRATION OF AUTHORIZATION

Unless I request in writing otherwise, I understand that this authorization will expire on ________________. If I do not specify an expiration date or event, this authorization will expire ninety(90) days from the date on which I signed this authorization.

5. RIGHT TO REVOKE AUTHORIZATION

I understand that I have a right to revoke this authorization. I must do so in writing and present my written revocation to Medical Records at Just Us Kids Pediatrics. I understand that the revocation will not apply to and health information that has been released in response to this authorization.

6. RE-DISCLOSURE

I understand that if my health information is disclosed to a party other than a health care provider, health plan or health care clearing house subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

7. FEES

I understand that federal and state laws allow a fee to be charged for the copying of patient records and I will be responsible for the payment of such fees, if they do occur.

8. RELEASE & WAIVER

If the health information that I have requested Just Us Kids Pediatrics to disclose contains any privileged psychiatric or psychological information related to the treatment of physical/ or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as Acquired Immunodeficiency Syndrome (AIDS), Tuberculosis, or Hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release Just Us Kids Pediatrics and their officers, trustees, agents and employees from any and all liabilities, damages, and claims, which might arise from the release of the health information authorized by me above.

_______________________________________ _______________________
Signature of Patient (or patient's representative) Date

_________________________________ _______________________
Printed Name of Patient or Representative Relationship to Patient

Just Us Kids Pediatrics
Appointment Policy

All patients with a scheduled sick or well appointment will need to call within 24 hours to cancel. If a 24 hour notice is not received, the patient will be charged a $25.00 broken appointment fee. We understand that sometimes emergencies do occur, in which we will waive the $25 fee.

As a courtesy, our office will attempt to contact you to confirm your child's appointment; however, we ask that you assume responsibility for your child's appointed time. Multiple broke appointments (3 or more) without prior cancellation notice, may be subject to dismissal from the practice.

We sincerely appreciate your cooperation with us.

Thank you.

Parent Signature: ________________________________

Date: ____________________

JUST US KIDS PEDIATRICS

Notice of Privacy Practice

As part of my health care, Just Us Kids Pediatrics originates and maintains paper and/or electronic records describing patients health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. This information serves as:

- A basis for planning patient care and treatment
- A means of communication among the many health professionals who contribute to patient care
- A source of information for applying my diagnose and surgical/treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

Consent to Disclosure of Patients Protected Health Information

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations such as quality reviews.

I understand and have been provided with the practice Note of Privacy Practice before signing this document.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my request, they must follow the restrictions.

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

I understand that by failing to sign or revoking this consent, the practice may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I fully understand and accept the terms of this consent.

Guarantor Recognition of Fiscal Responsibility

I understand that I am responsible at the time services are rendered. I also understand that even though the office, out of courtesy, may verify my benefits, this is not a guarantee of payment. All benefits and eligibility are subject to change without notice. The benefits we verify are only a general summarization and are not intended to be used as an authorization of services provided. In the event my insurance does not cover all charges, I agree to pay the balance due in a timely manner. I am also responsible to notify the office of insurance changes.

Signature: ______________________________ Date: ________________

(Patient, Parent, Legal Guardian)

If signed by representative, state relationship to patient:________________