HIPPA
ACKNOWLEDGMENT AND CONSENT
MINORS

I understand that my minor children's health information may include both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my children's health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

I understand & agree that This Practice may use & disclose my children's health information in order to determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some reason or all of my children's care; Perform various office, administrative and business functions that support my children's physician's efforts to provide me with, arrange and be reimbursed for quality, cost effective health care.
I also give Kids Clinic permission to:
(please initial)
_____ Make decisions about and plan for my children's care and treatment;
_____ Refer to, consult with, coordinate among and manage along with other health providers for my children's care and treatment;
_____ Leave detailed voice messages regarding the health / results of my child(ren).
_____ Contact patient family regarding appointment reminders.
_____ Contact patient family regarding services and treatments your child(ren) may need.
_____ Any photos i.e.: Christmas / graduation / etc. sent into Kids Clinic may be displayed (not for social or promotional uses)

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about my children. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my children's health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a more detailed current version of This Practice's Notice of Privacy Practices in effect will be posted in the reception area and on the Kids Clinic website at www.kidsclinic.us. I understand that if I have any questions about the Notice I may contact our office at 541-772-5548.

I understand that I have the right to ask that some or all of my children's health information not be used or disclosed in the manner described on the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that
____ I have received a copy of the Notice of Privacy Practices.
____ I am declining a copy at this time.

Responsible Party Signature: ____ Date:_______________

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Applicable to the following Child(ren)