

Release and Use of Confidential Information Receipt of Notice of Privacy Practice Form

I, _____, hereby acknowledge receipt of the physician’s Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

I, hereby give my consent to Vernon Hills Pediatric Associates, Ltd. to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained my child(ren) as listed on reverse side of this form.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician’s office.

✓ Signed: _____ Date: _____ Relationship to Patient(s) _____


Protected Health Information Disclosure Authorization Procedure

In order to communicate your Protected Health Information (lab test, diagnostic procedures, etc.) in a timely manner and in compliance with the Health Insurance Portability and Accountability Act, requests that you complete the form. This form confirms your authorization on what manner you prefer Vernon Hills Pediatric Associates, Ltd., to use and disclose your Protected Health Information and what information can be disclosed.

Use and/or Disclosure Authorized

The type of protected health information (PHI) I am authorizing to be used and/or disclosed are (please check appropriate boxes):

- Any diagnostic result Throat culture Blood tests Diagnosis
- Urine tests Xray Other: _____

 Please check the appropriate box to tell us where we can call you (include phone number) to inform you of your PHI and please check off how much information can be disclosed:

- Home: _____ Home answering machine Message to call back VHP for results
- Work: _____ Message with results on ALL answering Voice Mail
Machines except: _____
- Cell: _____

This authorization will be in effect for one year from the date of the signature. I may revoke this at any time by giving written notice to VHP. I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization.

I have read and thought about the content of this authorization form and I agree will all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

✓ **Signature:** _____ **Date:** _____

Patient, Parent or Legal Guardian

-Patient File