Shine
Pediatrics and Wellness Center, PA
P: 469.333.1543 F: 1-877-878-9118
shine@shinepediatrics.com www.shinepediatrics.com

# HIPAA Privacy and Authorization and Consent Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

## Consent for Treatment

I consent to the care and treatment of the patient(s) noted above by the healthcare providers of Shine Pediatrics and Wellness Center, PA, as may be prescribed by the same and/or dictated by professional standards of practice for any illness or condition. My consent for any procedures in the office is implied as well as documented under written agreement of my own faculties under this Authorization and Consent for Medical Treatment. I will ask prior to any procedure or treatment plan for clarification on anything I do not understand.

1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information ("PHI") described below.
2. I hereby authorize the release of PHI for all past, present and future periods until revoked in writing.
3. I hereby authorize the release of PHI as follows (check one):
   a. ☐ complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse)
   OR
   b. ☐ complete health record *with the exception of the following information* (check as appropriate):
      - ☐ Mental health records
      - ☐ Communicable diseases (including HIV and AIDS)
      - ☐ Alcohol/drug abuse treatment
      - ☐ Other (please specify):_____

Initials

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## Authorization and Consent of Parent(s) or Legal Guardian(s)

I do have legal custody of the aforementioned minor child named above. I grant my authorization and consent for the Supervising Adults named below in case of an injury or illness that is life threatening or in need of a treatment, that the Supervising Adult can summon any and all professional emergency personnel to attend, transport, and treat the participant and to issue consent for any x-ray, anesthetic, blood transfusion, medicationor other medical diagnosis, treatment or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Supervising Adult in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

4. The Supervising Adult(s) are listed below:

   Name_____ Relationship_____

   Name_____ Relationship_____

   Name_____ Relationship_____

5. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

6. This authorization shall be in force and effect until nine (9) months after my death or until revoked in writing.

7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____
Printed Name of Parent/Legal Custodian

_____ _____
Signature of Parent/Legal Custodian Date