13643 S. Mur-Len Rd.
Olathe, KS 66062
913-764-7060
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Amy Voelker, M.D., FAAP
Allison Hettinger, M.D., FAAP
Shawna Patch, M.D., FAAP
Connor Hosty, M.D., FAAP

Preferred Pediatrics

Authorization for Disclosure of Protected Health Information

FOR PATIENT 18 YEARS AND OVER

As required by the Health Information Portability and Accountability Act of 1996, (HIPAA), your protected health information is confidential unless written authorization is given.

I have reviewed/had access to a copy of the Notice of Privacy Practices of Preferred Pediatrics on the date indicated below and understand the content. This form will be updated yearly or any time changes need to be made. This notice was published and became effective 03/2013.

I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted in the office of Preferred Pediatrics.

I also understand that if I wish to receive a copy of this Notice of Privacy Practices in the future or I have any questions with regard to this Notice of Privacy Practices, I may contact the Privacy Officer at the office of Preferred Pediatrics at the main phone number. I consent to the use and disclosure by Preferred Pediatrics of protected health information for purpose of treatment, payment and healthcare operations.

Therefore, I, _____ (Print your Name) hereby authorize Preferred Pediatrics, to give protected health information to myself and the following persons.

LIST ALL PARENTS/STEP PARENTS OR OTHER CARE GIVERS OR WE WILL NOT BE ABLE TO DISCUSS CARE WITH THEM

Name:	**Relationship:**
_____	_____
_____	_____
_____	_____

DO NOT disclose protected health information to anyone other than me _____ (initials)

____ **DO** ____ **DO NOT** leave messages on my answering machine or voicemail. Phone Number: _____

____ **DO** ____ **DO NOT** use my email. Email Address: _____

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This remains in effect from 1 year of date signed.
I also understand that, in an urgent medical situation, Preferred Pediatrics may need to contact me by any means available.

_____ _____

SIGNATURE OF PATIENT DATE