HELPING HANDS PEDIATRICS

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Helping Hands Pediatrics to use and/or disclose certain protected health information (PHI) about me to _____. This
Name of entity to receive this information
authorization permits Helping Hands Pediatrics to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

_____

_____.

The information will be used or disclosed for the following purpose:

_____.

If requested by the patient, purpose may be listed as "at the request of the individual."
The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.
{Expiration Date or Defined Event}

The Practice will ___ will not ___ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Helping Hands Pediatrics. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

My written revocation must be submitted to the Privacy Officer at:

_____
Address

_____ _____ _____
City State Zip Code

Signed by:_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION

HELPING HANDS PEDIATRICS

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

PATIENTS PLEASE NOTE: THE PRACTICE IS NOT REQUIRED TO AGREE TO YOUR REQUEST. PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION REGARDING SUCH REQUESTS.

Patient Name:_____ Date of Birth:_____

Patient Address: _____
Street

_____
Apartment #

_____
City, State Zip

Type of PHI to be restricted or limited: (Please check all that apply)

- ☐ Home phone #
- ☐ Home address
- ☐ Occupation
- ☐ Name of employer
- ☐ Visit notes
- ☐ Hospital notes
- ☐ Prescription information
- ☐ Patient history
- ☐ Office address
- ☐ Office phone #
- ☐ Spouse's name
- ☐ Spouse's office phone #
- ☐ Other _____

How would you like use and (or disclosure of) your PHI restricted?

_____

_____

_____ _____
Signature of Patient or Legal Guardian Date

FOR INTERNAL PURPOSES ONLY:

HELPING HANDS PEDIATRICS

REQUEST TO INSPECT AND COPY PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____
Street

_____
Apartment #

_____
City, State Zip

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the charge for this service is $_____ per page, with a minimum charge of $_____.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Print Name of Patient or Legal Guardian

FOR INTERNAL PURPOSES ONLY:

HELPING HANDS PEDIATRICS

PATIENT COMPLAINT FORM

Our practice values the privacy of its patients and is committed to operating our practice in a manner that promotes patient confidentiality while providing high quality patient care.

If the staff at _____ have fallen short of this goal, we want you to
Practice Name
notify us. Please be assured that your complaint will be kept confidential. Please use the space provided below to describe your complaint. It is our intent to use this feedback to better protect your rights to patient confidentiality.

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____
Name of Patient Date

_____ _____
Signature of Patient Phone Number