

Authorization for Release of Health Information

Release Records To: _____

Address: _____

Phone: _____ Fax: _____

Release Records From: _____

Address: _____

Phone: _____ Fax: _____

I hereby authorize the release of records on the following patients:

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

The information to be included for use and/or disclosure (Check One):

Complete medical record
 Portions of the record as specified below _____

The information will be used or disclosed for the following purpose (Check One):

Transfer medical record to another physician
 Other (please specify) _____

By signing below, I, as the parent/guardian, authorize the records release of the patient(s) indicated above. I understand that I may revoke this authorization at any time and that unless a previous date is specified it will automatically expire 12 months from the date this form is signed.

Printed Name: _____

Signature: _____ Date: _____

Cool Springs Pediatrics
508 Autumn Springs Ct, Suite 2B
Franklin, TN 37067
Phone: (615) 261-5437
Fax: (615) 261-5443

Medical History

Name of Patient _____ Date of Birth _____

Family Medical History

Please indicate if any family members (parents, siblings, grandparents, uncles, and cousins) have had any of the following conditions:

Diabetes _____	Mental Retardation _____
Cancer _____	Mental Illness _____
Tuberculosis _____	Jaundice _____
Seizures _____	Eczema _____
Heart Disease _____	Hay Fever _____
Kidney Disease _____	Frequent Sinusitis _____
Lung Disease _____	Asthma _____
Blood Disease _____	Food Allergies _____
Birth Defects _____	Drug Allergies _____
Inherited Diseases _____	High Blood Pressure _____

Social History

<input type="checkbox"/> Divorce, if so when? _____	<input type="checkbox"/> Separation, if so when? _____	<input type="checkbox"/> Death in family
<input type="checkbox"/> Severe Illness of family member	<input type="checkbox"/> New Addition to Household	<input type="checkbox"/> Recent move
<input type="checkbox"/> Other _____		

Please list all persons living with the patient and their relation to the patient:

Name	Relation	Name	Relation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Pregnancy and Birth

Due Date: _____ Birth weight: _____

Did mother have regular prenatal care: Yes No Unsure

Please describe any complications during this pregnancy: _____

Any medications, alcohol, tobacco, or other use during pregnancy? _____

Did the baby require medical intervention in the delivery room? Yes No Breast feed? Yes No
Require oxygen? No In delivery room only Longer, how long? _____

How old was the baby when discharged from the nursery? _____

Patient Registration Form

Last Name	First	MI	DOB	SSN	M/F

Address _____ **City** _____ **St** _____ **Zip** _____
 Home Phone _____ Phone To Contact for Reminder Calls _____
 Patient Cell Phone (Patient over 18) _____

Mother's Name _____ **SSN** _____ **DOB** _____
 Address _____ **City** _____ **St** _____ **Zip** _____
 Home Phone _____ Cell _____ Work _____

Father's Name _____ **SSN** _____ **DOB** _____
 Address _____ **City** _____ **St** _____ **Zip** _____
 Home Phone _____ Cell _____ Work _____

Stepmother's Name _____ **SSN** _____ **DOB** _____
 Cell Phone _____ Work _____

Stepfather's Name _____ **SSN** _____ **DOB** _____
 Cell Phone _____ Work _____

Billing Information(if different from patient's address) Name _____
 Address _____ **City** _____ **St** _____ **Zip** _____

Primary Insurance _____ Policy Holder's Name _____
 Subscriber ID Number _____ Group Number _____

Secondary Insurance _____ Policy Holder's Name _____
 Subscriber ID Number _____ Group Number _____

Local Emergency Contact _____ Relation to Patient _____
 Home Phone _____ Cell _____ Work _____

I hereby consent to treatment for my child, or the above named minor for whom I accept responsibility. I authorize release of information to any insurance carrier and direct payment to this office for any treatment rendered. I hereby acknowledge and accept final responsibility for payment of charges for services rendered, as well as any legal fees incurred by this practice in the event that action need be taken for the collection of such fees.

Signature _____ Date _____

HIPAA Notice of Privacy Practices

Cool Springs Pediatrics, PLLC
508 Autumn Springs Ct., Ste 2B
Franklin TN, 37067
Phone: (615) 261-5437

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following activities without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements or Section 164.500.

Other Permitted and Required Uses and Disclosures Will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization at any time in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternately i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice or our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____

**STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

Information to be Used or Disclosed

The information covered by this authorization includes:
X-ray results, test and lab results, medication dosage amounts, information regarding specialist appointments, general medical information, etc.

Persons Authorization to Use or Disclose information

Information listed about will be listed above will be used or disclosed by:
Employees of Cool Springs Pediatrics: including physicians, nurses, front desk, staff, etc.

Persons to Whom Information May Be Disclosed

Information described above may be disclosed to: an answering machine, the patient, his/her parent or legal guardian, caregiver, relative, grandparent, etc.

Expiration Date of Authorization

This authorization is effective through NO EXPIRATION unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Cool Springs Pediatrics. You should contact the Privacy Officer or a member of the front desk staff to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature

Name of patient (Print or type)

Signature of Patient

Date

Signature of Patient Representative

Relationship of Patient Representative to Patient