HIPAA Consent Agreement

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, El Paso Child Neurology originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

Notice of Private Practices

Your signature below acknowledges that you have reviewed the Privacy Practices Notice from the office of El Paso Child Neurology. A Copy is available upon request.

Authorization To Disclose & Use Information

Please provide phone number where we can leave a detailed message regarding your appointment.

To whom may we disclose information regarding your appointment and/or prescription(s)?

Who do you authorize to bring your child to their doctor's appointment? This person must be18 years of age, must present current TX ID, and must know the patient's medical history. Any other person who is not listed above will require a notarized letter and current TX ID.

I authorize El Paso Child Neurology to take a picture of my child. I am well aware that the sole purpose of this picture is for medical use only and that this picture will not be for public viewing.

_____ _____

Parent/Guardian Signature Date

Witness: _____

(Staff member)

Delivery Preferences of Medical Records

You have the right to receive your records by one of the following methods:

- Via USPS mail – if this method is of your preference we make every effort possible to protect your health information. Please be aware that we have no control of mail once it leaves our office. In addition charges will apply for the cost of certified mail.
- Via fax – this practice utilizes electronic faxing and manual faxing. We make every effort to protect your privacy. We will attach a fax cover sheet with the intended receiver's name along with your records. The fax cover sheet will instruct the receiver to call our office, destroy the records or return file to us if they are not the intended party.
- Via email – Although we make every effort in securing Protected Health Information (PHI). Please be advised that our email address does contain the word "Neurology" therefore if intercepted it could identify the patient's condition. In addition you may be required to upgrade or change your computer settings in order to receive secure messages.
- Hand delivered – this is our preferred method of releasing medical records. The risk of your records being intercepted or received by unintended party is minimal. However records will only be handed over to the party listed on the HIPAA agreement and an ID will be required at time of pick-up.

Regardless of the method used for delivery of records charges will apply. If you choose to receive records by USPS mail, via fax or via e-mail you will be asked to sign a waiver releasing El Paso Child Neurology of any liability in case your file is intercepted by unintended party. It is your choice to sign or decline the form without interruption of receiving your medical records.

Breach Notification Policy

In the case of a breach of unsecured protected health information, we will notify you as required by law. Although the law states we can notify you by email, El Paso Child Neurology will not be able to accommodate you using this method because our email address contains the word "Neurology" and can identify the patient's condition which is a violation of HIPAA. We will provide notification by other methods as appropriate.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

If you need to request restrictions for the use and disclosure of your health information please speak to the compliance officer for proper forms.

Signature_____ Date: _____