



HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient’s Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The Patient has the right to restrict the uses of their information.
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient’s behalf without this signed HIPAA consent form, therefore same day of service payment in full for any services will be required.

Patient name: _____

Signature of patient or guardian: _____

Relationship to the patient (if other than patient): _____

Today’s Date _____



PATIENT HEALTH HISTORY

Patient's Last Name: _____ Patient's First Name: _____ DOB: _____

Mother's Name: _____ Age: _____ Health: _____ Occupation: _____

Father's Name: _____ Age: _____ Health: _____ Occupation: _____

Patient's Brothers' Names and Birth Dates: _____

Patient's Sisters' Names and Birth Dates: _____

CHILD'S (PATIENT) BIRTH HISTORY

While pregnant did Mother:

Use alcohol, drugs or smoke? Yes__ No__

Get Sick? Yes__ No__

Need Special Test? Yes__ No__

Normal Labor? Yes__ No__

Health problems after labor? Yes__ No__

Have any special problems? Yes__ No__

-Explain: _____

Prenatal Care at: _____

Date of first prenatal visit: _____

Length of pregnancy: _____

Birth at: _____

Birth weight: _____ lbs _____ oz

How long in hospital? _____

CHILD'S (PATIENT) HEALTH HISTORY

Is this child taking medication on a regular basis? Yes__ No__

Name of Medication: _____

Immunizations up to date? Yes__ No__

On WIC program? Yes__ No__

Use a car seat or seat belt? Yes__ No__

Does anyone in the home or daycare site smoke? Yes__ No__

Had surgery? Yes__ No__

-Date and Problem: _____

Any Hospitalizations? Yes__ No__

-Date and Problem: _____

Date of last Well Child Exam: _____

Date of last Dental Exam: _____

FAMILY HEALTH HISTORY

Check if family members have had or have:

- () Diabetes
- () High Blood Pressure
- () Heart Disease under the age of 55
- () Asthma, Hay Fever or Allergies
- () Depression or Metal Illnesses
- () Tuberculosis (TB)
- () Epilepsy
- () Violent Behaviors
- () Deafness
- () Sudden Infant Death Syndrome (SIDS)
- () Alcohol or Drugs Use
- () Cancer
- () Sickle Cell Disease
- () Learning Disabilities
- () Parent Cholesterol over 240/mg/dl
- () Obesity
- () Other _____

Check all that apply to this child (patient)

- () Vision or Hearing problems
- () Ear Infections
- () Pneumonia, Bronchitis or Cough
- () Asthma or Breathing problems
- () Hay Fever
- () Seizures
- () Bed Wetting
- () Anemia
- () Kidney or Bladder problems
- () Injury or Abuse
- () Obesity
- () Substance Abuse (age 12-18)
- () Allergies: _____
- () Other: _____

PARENTAL CONCERNS ABOUT THIS CHILD

Behavior? _____

Development? _____

Nutrition? _____

Substance Abuse (age 12-18)? _____

Other? _____

PARENT'S SIGNATURE: _____

TODAY'S DATE: _____

EPSDT LEAD SCREENING QUESTIONNAIRE

Child's Name: _____ Date of Birth: _____

Beginning at six months of age and at each visit thereafter, children should be assessed for risk of lead exposure. Ask the following questions at a minimum. **If the answer to any question is positive, a child is potentially at high risk for lead exposure. A blood lead test may be obtained at the time a child is determined to be high risk.**

YES (Only check if applies)

- Does your child live in or frequently visit a house built before 1970 that has peeling or chipping paint?
- Does your child live in a house built before 1970 with recent, ongoing or planned renovation or remodeling?
- Have any of your children or their playmates had lead poisoning?
- Does your child frequently come in contact with an adult who works with lead (examples are: construction, welding, pottery, etc.)?
- Does your child live near a lead smelter, battery recycling plant or other industry likely to release lead?
- Do you give your child any home or folk remedies that may contain lead?
- Does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead?
- Does your home plumbing have lead pipes or copper with lead solder joints?

PARENT SIGNATURE: _____ DATE: _____

MEDICAL RELEASE/AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION
North Sound Pediatrics

Patient's Name: _____	Date of Birth: _____
Address: _____	
Phone #: _____	

AUTHORIZATION:

I authorize North Sound Pediatrics to release or obtain protected health information of the above-named patient.

TYPE OF RECORDS REQUESTED:

- All Medical Records Immunization Records Billing Records
 Records related to a specific illness or injury: _____
 Records for the following date(s): _____
 Other: _____

PURPOSE FOR THIS REQUEST:

- Personal Transfer of Care School Legal Other: _____

HOW SHOULD NORTH SOUND PEDIATRICS HANDLE THIS REQUEST?

- | | |
|---|--|
| <input type="checkbox"/> Please give patient's records to me in person | <input type="checkbox"/> Please mail patient's records to me at the address above |
| <input type="checkbox"/> Please request patient's records from the following: | <input type="checkbox"/> Please send patient's records to the following: |

Name of Provider/Facility/Individual

Address

City/State/Zip

Phone # / Fax #

Name of Provider/Facility/Individual

Address

City/State/Zip

Phone # / Fax #

I UNDERSTAND THAT:

- My right to healthcare treatment is not conditioned on this authorization.
- Authorizing the disclosure of this healthcare information is voluntary.
- I may cancel this authorization at any time by submitting a written request to North Sound Pediatrics.
- Once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further distribution by the recipient that may not be protected by confidentiality laws.
- There may be a charge for the requested records.
- This authorization will expire one year from the date of signing, unless revoked.

Printed Name of Person Completing Form

Relationship to Patient

Signature of Person Completing Form

Date

Disclaimer: This document and the information in it does not constitute legal advice. It is also not a substitute for legal or other professional advice. Users should consult their own legal counsel for advice regarding the application of the law and this document as it applies to the HIPAA regulations.