INDIAN CREST
PEDIATRICS

DATE _____

Patient Name: _____ DOB: _____

CONSENTS

HEALTH INFORMATION EXCHANGE: Indian Crest Pediatrics endorses, supports, and participates in electronic Health Information Exchange (HIE) to improve the quality of your health and healthcare experience. However, you may choose to opt-out of participation in the CORHIO HIE or cancel an opt-out choice at any time.

CONSENT TO COPY MEDICAL RECORDS: I understand that it may be necessary for other healthcare providers to review information in my child's medical record to render medical care to my child. I authorize Red Rocks Pediatrics to copy part or all my medical record if another healthcare provider needs it to provide medical treatment.

CONSENT FOR TREATMENT: I, the undersigned, voluntarily agree to the tests, procedures and/or treatments which the attending physician has deemed necessary, and which is administered to or performed on my child under the direction of the attending physician and his/her designees.

CONSENT TO E-MAIL: I understand that there may be times that the providers and/or staff of Indian Crest Pediatrics may request e-mailed documentation**. I understand that E-mail communication should NOT be used for general, emergent, or urgent messages as it is not monitored on a daily basis.** I understand that I need to contact the office for appointment requests and medical questions. I understand that electronic communication is not secure.

My signature indicates that I have read and agree to ALL terms set above.

Signature of patient/parent/legal guardian_____Date_____

PHONE MESSAGE CONSENT: There may be times when a physician or staff member may need to contact **YOU** with medical information (including but not limited to lab results, referral information and appointment information) via telephone. By filling in the information below you will be allowing us to leave medical information on **YOUR** answering system at the designated number(s). You may also allow us to leave a message regarding medical information with a designated person (i.e., grandparent or daycare provider, etc.) other than patient, parent or legal guardian (if patient less than 18 years of age). I fully understand that it is my responsibility to notify Indian Crest Pediatrics with any changes in my contact information and this will remain in effect until revoked in writing.

Name _____ Relationship to Patient_____ Phone Number_____

Name _____ Relationship to Patient_____ Phone Number_____

HIPAA POLICY: The undersigned patient or legally authorized representative of the patient acknowledges that he or she personally received or was offered a copy of the Indian Crest Pediatrics Privacy Policy on the date indicated below.

Printed Name _____ Relationship to Patient _____

Signature _____ Date _____

OFFICE USE ONLY: We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason:

_____

Employee Signature _____ Date _____