



NOTICE OF PRIVACY AND CONSENT FOR CARE

PRIVACY PRACTICES: Pediatric Associates of Durango maintains a record of the health care services that are provided to our patients. We will share this information, as permitted by law, to provide medical treatment, run our organization, and bill for these services. You have the right to view, obtain a copy, or amend these records, if needed.

Our ***Notice of Privacy Practices*** describes in more detail your rights to your health information and how this information may be used and disclosed. Sharing of your health information is typically used to improve the continuity of care that you receive. Common examples include sending immunization records to our state registry, use of a Health Information Exchange (HIE) with other health care organizations involved in your care, and accessing your prescription history from pharmacy benefits. If you have questions or want to discuss options for decreased information sharing, please contact our Compliance Officer.

CONSENT FOR CARE: I hereby authorize Pediatric Associates of Durango to institute any necessary care in my absence, including hospitalization, for the patients above. Further I support an integrated approach to healthcare and authorize the behavioral health providers to share, review and discuss any information provided during conversations, informal meetings or therapy session with the providers in order that they are able to provide the most comprehensive plan of care.

PLEASE INITIAL THOSE THAT APPLY:

_____ I understand that all parents/ legal guardians have access to full disclosure, even if they are not the custodial parent, and both can authorize care representatives, unless parental rights have been terminated by a court order. I understand that if there are custody orders in place, I must present current copies for my child's file.

_____ I authorize the people listed therein to bring my child to any appointments in the event of my absence, and give Pediatric Associates of Durango permission to call and leave a message regarding my child's clinical care, including lab and x-ray results, in my absence.

_____ I authorize Pediatric Associates of Durango to access information about medications I / my child/ my children have been prescribed in the past.

_____ I authorize Pediatric Associates of Durango to fax any forms or immunization records to my child's school upon my request.

THE UNDERSIGNED HEREBY CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE ABOVE STATED CONDITIONS OF CONSENT AND HAS RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR ANY AND ALL PATIENTS LISTED ABOVE.

Responsible Party Full Name

Responsible Party Signature

Date

Client Signature

Date