HIPAA Policy/Consent

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health concerns.

When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice. I acknowledge that this consent will remain in effect for 24 months from the date of this consent unless I revoke it earlier as described above.

I hereby given consent to the office of Lone Star Kids Care to use and disclose my (or my child's) protected health information for the purposes of treatment, payment, or healthcare operations.

Signature: ____________________________ Date: ____________________________

Printed Name: ________________________ Relationship to Patient: ______________

I am allowing the following persons (in addition to parent(s) or guardian(s) to receive private health information about my child. Please understand that if there is a person who is not named below accompanying my child to the doctor they must have a written and signed document by the parent or guardian that allows the accompanying adult to receive care and information for and about my child.

Name of person(s), other than parent or guardian, allowed to accompany child or receive medical information:

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Name of person(s) NOT allowed to receive information. ***Please bring this to the attention of the receptionist.***

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Names or addresses that may NOT be used to contact parent or guardian. ***Please bring this to the attention of the receptionist:***

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Signature: ______________________________________ Date: __________________________