CAROLINA KIDS PEDIATRIC ASSOCIATES, PLLC
2605 Blue Ridge Road Suite 100, Raleigh N.C. 27607
Phone: (919) 881-9009 Fax: (919) 881-8463

Permission or Denial of Access to Personal Health Information

Patient's Full Name: _____ **Date of Birth:** _____

Phone Number: _____ **Email:** _____

I authorize _____ to use and disclose my protected health information as specified below: *(Please circle yes or no for each field)*

Yes No 1) Schedule and cancel appointments on my behalf
Yes No 2) Discuss medical concerns with available nurse/physician
List any exclusions (i.e. mental or sexual health) _____
Yes No 3) Have access to all records
List any exclusions (i.e. mental or sexual health) _____
Yes **No*** 4) Send bills to responsible party on file. ***PLEASE NOTE,*** this may alert the individual that you were in our office. ***IF NO***, complete the following information and know that you are accepting personal responsibility for any balances that are owed.

***Billing Address: _____**

City:_____ State: _____ Zip: _____

I understand that if Carolina Kids files my insurance, the insurance company may give access to or send information to the primary policy holder regarding your visit. *See a staff member if you wish to decline insurance filing.*

I understand that if I give authorization to have my protected health information disclosed to a third party who is not required to comply with HIPAA regulations, then the third party may not protect my information.

I understand that I have the right to revoke this authorization at any time and that my revocation must be in writing. Completing an updated copy of this form can be considered a written revocation.

I have read the above terms and I am aware that a copy of the authorization is available upon request at any time. Unless revoked or replaced, this authorization will expire two years from the date it is signed.

Patient's Printed Name: _____

Patient's Signature: _____ Date: _____