Name of Child: _____ **Date:** _____

School Attending: _____

HIPAA Notice of Privacy Practices

I understand, that as, part of my health care, Erlanger Health System, receives, originates, maintains, discloses, and uses my protected health information, including, but not limited to, health records and other health information describing my health history, symptoms, examinations and test results, diagnoses, treatment, treatment plans, and billing and health insurance information. Health information is maintained both in paper format and electronic media. I authorize Erlanger Health System to use this information for the purpose of treatment, payment, or healthcare operations. This authorization specifically includes the release of medical information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or infectious diseases included but not limited to blood-borne diseases. I understand that I may revoke this consent in writing and Erlanger Health System will comply if possible. However, Erlanger Health System will not be held responsible for any actions or disclosures already taken prior to revocation of this authorization.

I have been provided a ***Notice of Privacy Practices*** that fully explains the uses and disclosures that Erlanger Health System may make with respect to my protect health information. I understand that I have the right to review the **Notice** before signing this consent. I also understand that Erlanger Health System reserves the right to change the ***Notice of Privacy Practices*** and should the privacy practices change, I will be notified of any changes upon my next visit to Erlanger Health System. Also, I may obtain a current copy of this notice at **www.erlanger.org**.

I understand that I do not have to consent to use or disclosure of my protected health information for treatment, payment, and health care operations. If I do not consent, Erlanger Health System may refuse to provide me health care services unless applicable state or federal laws require Erlanger Health System to provide such services.

I understand that I have the right to request restriction on the use or disclosure of my protect health information to carry out treatment, payment, or health care operations. I further understand Erlanger Health System is not required to agree to the requested restriction but that, if it does agree, it is bound by such agreement. If a request for restriction on the use or disclosure of individually identifiable health information is made the Corporate Privacy and Security Officer (CPSO) is to be notified immediately. No one is authorized to accept a request for restriction other than the CPSO.

I understand that I may revoke this authorization in writing and Erlanger Health System will comply if possible. However, Erlanger Health System will not be held responsible for any actions or disclosures already taken prior to revocation of this authorization.

Signature of Parent or Legal Representative **Relationship to Patient**

_____ _____

Date: _____