McComb Children's Clinic
309 Llewellyn Ave.
McComb, MS 39648

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my child's treatment and follow-up among the providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PHARMACY BENEFITS MANAGEMENT

McComb Children's Clinic has my permission to speak with my insurance company about my pharmacy benefits.

_____YES _____NO

STATEMENT TO PERMIT PAYMENT OF INSURANCE BENEFITS TO PROVIDER

I also request that payment of authorized insurance and/or Medicaid benefits be made on my behalf to the McComb Children's Clinic. I authorize any holder of medical or other protected information about my child to release to the insurance company or Division of Medicaid or its Fiscal Agent any information needed to determine these benefits or the benefits payable for related service.

THIS AUTHORIZATION IS GOOD FOR MY LIFETIME.

CHILD'S NAME _____

SIGNATURE_____DATE_____

RELATIONSHIP TO PATIENT _____

WITNESS_____DATE_____

Authorization for Disclosure of Health Information

Occasionally, you may find it helpful for our clinic to be able to discuss your child's health information with family members, friends, or school officials. For example, someone other than you or your spouse may need to bring the child to the clinic for a visit or pick up a prescription. We will be unable to discuss your child's care or to give out a prescription to anyone else unless we have your permission to do so.

I authorize

McComb Children's Clinic

309 Llewellyn Ave.

McComb, MS 39648

To disclose the health information of:

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

To the following individuals (list family members, friends, or school officials who may receive information about your child):

I understand that the information in my child's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire upon the child reaching the legal age of majority.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Yvette Chisholm, Privacy Officer for McComb Children's Clinic.

_____ _____

Signature of patient or legal representative Signature of witness

Date: _____ Date: _____

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701.243) and federal law 42 CFR, part II.