UNIFOUR FAMILY PRACTICE

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**HEALTH INSURANCE PORTABLITY AND ACCOUNTABILITY ACT (HIPPA) FOR CHILDREN**

Due to Federal Regulations concerning patient privacy, it is necessary for you to let us know the best way to inform you of your child/children’s medical information.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, THE PARENT/LEGAL GUARDIAN OF CHILD/CHILDREN’S NAMES LISTED BELOW REQUEST THAT I AM NOTIFIED OF MY CHILD/CHILDREN’S MEDICAL INFORMATION IN THE FOLLOWING MANNER.

Names:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAMES:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please read the following statements very carefully and (**CHECK ALL THAT APPLY)**

\_\_\_\_\_ Only discuss my child/children’s health and financial information with me.

\_\_\_\_\_ You have my permission to mail information to my home address.

\_\_\_\_\_ Please do not mail medical information to my home address, but to the following address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ You have my permission to leave any medical information, test results, etc., pertaining to my child/children on my answering machine or voice mail at the numbers listed.

 Home Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Work Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ You may communicate with me via email through Unifour Family Practice Patient Portal.

 My email address is (Please print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_ If I cannot be reached via telephone, you have my authorization to discuss my child/children’s medical information with the following individuals:

|  |  |  |
| --- | --- | --- |
| NAME | TELEPHONE NUMBER | RELATIONSHIP |
|  |  |  |
|  |  |  |
|  |  |  |

COMMENTS:

 **AS A PATIENT OR LEGAL GUARDIAN IT IS YOUR RESPONSIBILITY TO LET US KNOW IF ANY OF THE ABOVE INFORMATION CHANGES AT ANY TIME**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WITNESS DATE