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Authorization by Parent or Legal Guardian for another Person to Bring Minor to Physician's Office

Names of Children	**Dates of Birth**
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

I hereby provide permission for the following persons to bring my child(ren) to the office.

Names	**Relationship to Child(ren)**
______________________	______________________
______________________	______________________
______________________	______________________

I understand that when the person(s) identified above takes my child(ren) to Riviera Pediatrics for a medical problem, the part of my child(ren)'s protected health information that the medical provider determines relevant to the office visit may be disclosed to this person.

I understand that when the person(s) identified above takes my child(ren) for a well visit or for treatment of a medical problem that this person may need to provide consent for my child(ren) to receive medical services the health care provider determines necessary for the care and treatment of my child(ren). I hereby authorize the person(s) listed above to provide consent for the provision of the following medical services to my child(ren) by the medical providers of Riviera Pediatrics. I understand I will be responsible for all costs associated with these services.

* Evaluation   *Treatment   *Administration of vaccines

______________________	______________________
Name of parent or Legal Guardian	Signature
______________________	______________________
Relationship to Child(ren)	Date

This authorization shall be valid for each visit that the person(s) identified above takes your child(ren) to Riviera's office unless you provide written notice to Riviera Pediatrics that you are revoking

Acknowledgment of Receipt of
Notice of Privacy Practices
(Federal HIPAA Privacy Regulations)

By my signature below I am acknowledging that the office of RIVIERA PEDIATRICS has provided me with a copy of their " Notice of Privacy Practices".

Children's Names:	DOB

Parent or Guardian Printed Name:____________________________

Signature:____

Date:____

RIVIERA PEDIATRICS

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION.

With my consent, RIVIERA PEDIATRICS may use and disclose protected health information (PHI) about my child to carry out treatment, payment and healthcare operations (TPO).

Please refer to this practice Notice of Privacy Policy for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Policies prior to signing this consent.

RIVIERA PEDIATRICS reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to RIVIERA PEDIATRICS 4115 Office Plaza Boulevard, Indianapolis, IN 46254.

With my consent, RIVIERA PEDIATRICS may mail to my home or other designated locations any item that assists the practice in carrying out TPO: appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results, among others. I understand that I will be asked to complete an "Authorization to Leave Message Form" when medically required.

I have the right to request that this practice restrict how it uses or discloses my child's PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, I understand that this practice may decline to provide treatment to my child. This consent for treatment, payment and operations has no expiration date unless revoked in writing by the parent or legal guardian.

PATIENT NAME (S):	**DOB**

Parent or Guardian Printed Name: ______________________________

Signature: ______________________________

Date: ______________________________

RIVIERA PEDIATRICS

PATIENT PERMISSION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES.

By signing this form, I permit RIVIERA PEDIATRICS to disclose certain protected health information (PHI) about my child to the party or parties listed below.

This permission permits RIVIERA PEDIATRICS to disclose the following individual identifiable information:

____ Immunization Records

____ Health or Daycare Forms

____ Sports Forms

____ Medication and Nutrition Forms

____ Other: (Must be specific) ____

Release the above information to the following:

____ School Nurse/Athletic Director

____ Daycare Director

____ State or County Health Department

When the information is disclosed according to the permission, it may be re-disclosed by the recipient and may no longer be protected by the Federal HIPPA Privacy Rule.

I have the right to revoke this permission in writing except to the extent that RIVIERA PEDIATRICS has already acted in reliance upon this permission.

PATIENT'S NAME:	**DOB**

Address of Patients: ____

Printed Name of Parent or Legal Guardian: ______________________________

Signature of Parent or Legal Guardian: ________________________________

Date: ____