Riviera pediatrics

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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 and/or release billing/financial information

Names	Relationship	Financial Release
_____	_____	☐ Y ☐ N
_____	_____	☐ Y ☐ N
_____	_____	☐ Y ☐ N

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 heath information that the medical provider determines relevant to the office visit may be disclosed to this person. I understand that if designated, financial billing information may be disclosed to the person(s) above.

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.

By signing below I am also acknowledging that the office of Riviera Pediatrics has provided me with a copy of their "Notice of Privacy Practices" as mandated by Federal HIPAA Privacy Regulations.

*Evaluation *Treatment *Administration of vaccines

_____ _____
Name of Parent or Legal Guardian Signature

_____ _____
Relationship to Child(ren) Date

This 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 authorization.

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, Indiana 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 and "Authorization to Leave Message Form" when medically required.

I have the right to request that this practice restrict how it uses or disclose 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	DOB
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Parent or Legal Guardian Name (please print)_____

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:

_____Immunization Records

_____Health or Daycare Forms

_____Sports Physical 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 HIPAA 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 NAME	DOB
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Address of Patients_____

Printed Name of Parent or Legal Guardian_____

Signature of Parent or Legal Guardian_____

Date_____