Pediatric Endocrinology of Rhode Island

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PRIVACY PRACTICES (HIPAA)

By signing below I acknowledge that I was provided with the Notice of Privacy Practices of Pediatric Endocrinology of Rhode Island.

Signature of patient/legally responsible party:_____Date: _____

Printed name of legally responsible party: _____

Please list any other persons to whom the protected health information can be disclosed *(e.g., parent, family member etc.).*

Name:_____Relationship: _____

Name:_____Relationship: _____

PERMISSION TO LEAVE MESSAGES:

By Signing Below, I authorize Pediatric Endocrinology of Rhode Island to leave non clinical messages in reference to any items that assist in carrying out the healthcare.
What is the best number to reach you: (____)_____
Can we leave messages at this number? Yes __ No __
Would you like to receive TEXT reminders? Cell: (____)_____
Would you like to receive EMAIL reminders: Email: _____

Signature of patient/legally responsible party:_____Date: _____

Printed name of legally responsible party: _____

RX HISTORY CONSENT:

By signing below, I agree to allow Pediatric Endocrinology of Rhode Island to review any prescription history available to the electronic health record.

Signature of patient/legally responsible party:_____Date: _____

Printed name of legally responsible party: _____

Disclosure Of Protected Health Information Of A Minor *(only applicable for minor patient's 11-18 years)*

I understand that medical records containing the following information about the care listed below

- HIV testing and treatment
- Testing and treatment for reportable sexually transmitted diseases
- Family Planning and abortion services
- Alcohol and drug treatment services

by law, cannot be disclosed by Pediatric Endocrinology of Rhode Island to the parent/guardian of a minor patient unless permission is granted by the minor. On some occasions, PERI may call the minor about the release of his/her information.

Minor cell phone number: _____