KIDS FIRST PEDIATRICS

growing families one kid at a time

Identification of Personal Representatives

Patient:_____ Date of Birth:_____

I hereby authorize Kids First Pediatrics to disclose my protected health information (as described below) to the individual(s) named below. I understand the protected health information released to the individual(s) named below may be further disclosed by the recipient and no longer protected by Federal law. I understand the Kids First Pediatrics patient portal allows me to make changes to who can access my health records inside the portal. However, I also understand that it is the most current edition of this document that determines to which designated personal representative(s) Kids First Pediatrics staff are permitted to disclose my protected health information.

Parents of Children 18 Years and Younger

State laws provide access to protected health information by biological parents regardless of marital situation unless a court has imposed alternative parental guardianship, or a parent has legally relinquished parental rights. To assure privacy and protection of a child's protected health care information, please list the biological parent below:

Print the Name of Mother	Date of Birth	Phone #	Email
Print the Name of Father	Date of Birth	Phone #	Email
Print the Name of Legal Guardian	Date of Birth	Phone #	Email

If your child has been adopted by you or your spouse, please provide a copy of the official adoption decree.
If your child is under joint custody, please provide a copy of the official Custody Order.
If a child is under guardianship, please provide the court documents citing who is the child's legal guardian.

All legal documents provided will be held confidentially and are considered part of the child's medical record, thus will be considered and treated as protected health information.

I authorize Kids First Pediatrics to disclose the following protected health information:

- ☐ I authorize Kids First Pediatrics to disclose ALL of my protected health information (all departments). This information may include clinical information about my care, as well as billing information related to my health insurance coverage and payment activity for services rendered by Kids First Pediatrics.
- ☐ I authorize Kids First Pediatrics to disclose ONLY the protected health information listed below:

_____

Below are the family members/friends/others who may receive the protected health information described above.

Print the Name of Personal Representative	Date of Birth	Phone #	Email	Portal Access? Yes-full Billing No
Print the Name of Personal Representative	Date of Birth	Phone #	Email	Portal Access? Yes-full Billing No
Print the Name of Personal Representative	Date of Birth	Phone #	Email	Portal Access? Yes-full Billing No
Print the Name of Personal Representative	Date of Birth	Phone #	Email	Portal Access? Yes-full Billing No

I understand that except to the extent that action already has been taken based on my authorization, I may revoke this authorization at any time by written notification to Kids First Pediatrics at 6312 Hwy 41A, suite 102; Pleasant View, TN 37146.

Kids First Pediatrics will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on my provision of this authorization. I understand that I may refuse to sign this authorization and that Kids First Pediatrics will not retaliate if I refuse. I understand I have a right to receive a copy of this authorization.

Signature of Patient or Representative: _____ Date: _____

Printed name of Patient or Representative: _____

Relationship to Patient: _____