Patient Consent & Authorization for Release of Information HIPAA

Heber Valley Medical | 345 E Gateway Dr #150, Heber City, UT 84032 | 435-657-0101

1. General Consent for Treatment

I, the undersigned, hereby consent to the healthcare services, diagnostic procedures, and medical treatment provided by **Heber Valley Pediatrics** for: **Patient Name: _____ DOB: _____**

I understand that this care may include clinical exams, laboratory tests, immunizations, and the use of healthcare technology (including secure telehealth or AI-assisted clinical documentation) to ensure the highest quality of care.

2. HIPAA Acknowledgment

I acknowledge that I have been offered or received a copy of the **Notice of Privacy Practices (NPP)**, updated as of February 16, 2026. I understand my rights regarding the privacy of my child's Protected Health Information (PHI).

3. Mandatory 2026 Redisclosure Notice

I understand that once my child's health information is disclosed to a third party (such as an insurance company, school, or outside specialist) pursuant to this authorization, **Heber Valley Pediatrics** cannot guarantee that the recipient will not "redisclose" that information. Once redisclosed, the information may no longer be protected by federal HIPAA privacy regulations.

4. Substance Use Disorder (SUD) Records

I understand that federal law (42 CFR Part 2 and HIPAA) provides specific protections for records related to Substance Use Disorder. By signing this form, I acknowledge that:

- These records will not be used in civil, criminal, or administrative proceedings against the patient without express written consent or a specific court order.
- If SUD records are shared with a Health Information Exchange (HIE), they remain protected under these 2026 federal standards.

5. Your rights:

- **Access Records:** You have the right to inspect and receive an electronic or paper copy of your child's medical record.
- **Amend Records:** You can ask us to correct information you think is incorrect.

- **Request Restrictions:** You may ask us not to share certain information for treatment or payment.

6. Communication Preferences (Check all that apply):

[ ] I consent to receive appointment reminders via SMS/Text.

[ ] I consent to receive communication via the Secure Patient Portal.

Release of information

[ ] I authorize the following individuals to receive medical info/pick up my child:

Name: _____

Relationship: _____

Signature of Parent/Legal Guardian: _____

Printed Name: _____ Date: _____

Relationship to Patient: _____