Springboard Pediatrics

2980 N Main Street, Suite 2 ● Decatur, IL 62526 ● Phone: 217-876-8000 ●·Fax:217-876-8588
www.springboardpeds.com

ACKNOWLEDGEMENT FORM

Medical Records #_____

Patient's Name:_____ **Date of birth _____/_____/_____**
Day Month Year

We are required by law to provide you with our Notice of Privacy which explains how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

Signature:_____ **Date:_____**
(Patient or Authorized Representative)

Full Name: _____

Relationship to Patient: ☐Mother ☐Father ☐Self ☐Other _____

Reason Patient Unable/Unwilling sign: _____

ACKNOWLEDGEMENT FORM (en espanol)

DOCUMENTO DE RECONOCIMENTO DE SPRINGBOARD PEDIATRICS

Numero de Registro Medico_____

Nombre del Paciente _____ **Fecha de Nacimiento ___/___/___**
Dia Mes Ano

La ley nos que requiere que nosotros le proveamos a usted con nuestro Aviso de Practicas de Privacidad las cuales explican podemos usar y divulgar su informacion medica. La ley tambien nos requiere que obtengamos su firma, reconociendo que este aviso lo hemos hecho disponible para usted.

Firma:_____ **Fecha:_____**
(Paciente o Representante Autorizado)

Relacion al Paciente y nombre: ☐Madre: _____ ☐Padre: _____ ☐**Otro** _____

Razon Por la Cual El Paciente No Puede/No Desea Firmar: _____

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Consent for Medical Services

I voluntarily consent for my child _____to be examined and evaluated by **Springboard Pediatrics**. I also agree to any routine test to be administered as deemed necessary. Included in this agreement is permission for treatment as indicated and referral to other appropriate health facilities necessary.

_____ _____
Signature of Parent/Legal Guardian Date

Vaccine Administration Consent Form

I _____authorize **Springboard Pediatrics** to administer any
Please print name
Immunizations as recommended by the American Academy of Pediatrics and Illinois Department of Health Services Immunization Branch to my child _____.
Please Print Child's Name

_____ _____
Signature of Parent/Legal Guardian Date

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AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient: _____ **Date of Birth**: _____
Springboard Pediatrics is authorized to release protected health information about the above named patient to the entities name below. The purpose is to inform the patient or others in keeping with the patient's instruction.

Person/Entity to Receive information (check each person/entity that you approve to receive information**)**

☐Spouse: Name:_____ Phone: _____
☐Parent Name:_____ Phone:_____
☐Other : Name:_____ Phone: _____

Consent for messages authorization

I authorize **Springboard Pediatrics**, its representative, physicians and staff to leave me a message if unable to reach me through the following methods:

☐ Voice mail phone number: _____ ☐ Email _____
☐ SMS text (mobile)_____

Description of information to be released:
(Check each that can be given to person/entity identified above)

☐ Result of lab test/ x-ray ☐ Financial Statements ☐Medical records ☐ Other_____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used as a result of this authorization may be subject to re-disclosure by the Recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. **This authorization shall be in effect until revoked by the patient or primary guardian.**

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Description of personal representative's authority (attach necessary documentation) Date

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AUTHORIZATION FOR MEDICAL RECORDS RELEASE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ DOB:_____
I authorize _____ Phone: _____ FAX: _____
(**Name of entity/physician that holds you records)**
Disclosure/ Release the above named individuals health information as described below (check all applicable):
☐All Records ☐ Abstract/Summary ☐ Laboratory/Pathology records ☐X-Ray's/EKG's ☐Billing Records ☐Physician Progress notes ☐Consultation Reports ☐Immunization Records ☐Other:_____

NOTE: If these records contain any information from previous providers about HIV/AIDS status, cancer diagnosis, alcohol abuse/drug and/or substance abuse, mental health notes, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

These records are for services provided on the following date(s):_____

Please send the records listed above to:

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Decatur, IL 62526
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The information may be used/ disclosed for each of the following purposes:
At my request (only patient can check this box)
☐For employment purposes ☐Continuation of Care ☐For payment/insurance ☐other _____

This authorization shall expire no later than: _____ or upon the following event (whichever is sooner): _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months. I understand that I have the right to cancel this authorization at any time. I understand that if I wish to withdraw this authorization I must do so on writing. I must present my written cancellation to the MD or Clinic Coordinator. I understand that the authorization withdrawal will not apply to information that has already been released due to this authorization. I understand that the cancellation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the release of the health information is voluntary. I do not have to sign this form to release treatment,. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the possibility for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of any health information, I can contact my physician's office Coordinator.

Print Name: _____ Date:_____

Signature: _____