Pediatric Associates of Hampton and Portsmouth

Over 18 HIPAA Release and Consent Form

Patient name: _____ Date of Birth: _____

Phone Number: _____

I understand and acknowledge that as of my 18th birthday, my parents and/or guardians will no longer be permitted access to my medical records, information, providers, billing inquiries, or appointment status without my specific written permission as checked of below. Pediatric Associates of Hampton and Portsmouth will not speak with my parents/guardians, permit my parents/guardians to schedule appointments or release medical information to my parents/guardians without my written consent in accordance with this document.

Name(s) granting access to: Relationship to patient:

_____ _____

_____ _____

Please **CHECK ONE** of the following options:

1. ____ **FULL ACCESS, NO RESTRICTIONS**. I give the named individual(s) permission to act on my behalf with **NO** limitations. I understand that they may contact any physician or member of the staff at Pediatric Associates of Hampton and Portsmouth to schedule appointments, discuss my healthcare, and access my complete medical records.
2. ____ **SCHEDULING APPOINTMENTS AND REFILLING PRESCRIPTION ACCESS ONLY**. I give the named individual(s) permission to contact and speak with any physician or member of the staff at Pediatric Associates of Hampton and Portsmouth to schedule/change an appointment and refilling/picking up prescriptions **ONLY**.
3. ____ **LIMITED ACCESS, SOME RESTRICTIONS**. I give the named individual(s) permission to act on my behalf **WITH** limitations. I understand that they may contact any physician or member of the staff at Pediatric Associates of Hampton and Portsmouth but **NOT** in regards to: (check which ones you **DO NOT** want us talking about)

   ____Mental Health ____Sexual Health/History ____Birth Control

   ____Drug/Alcohol Use ____Sexual Orientation or Identification

   ____Pregnancy ____Sexually Transmitted Infections (STI's)

   ____HIV/AIDS ____Access to Patient Portal ____Billing History

   ____Scheduling Appointments ____Refilling Prescriptions

   ____Other _____
4. ____ **I DO NOT GRANT ACCESS TO ANYONE**. No medical information, records, or appointment information can be discussed or released.

Patient Signature: _____ Date: _____

18+ Patient HIPAA Awareness

With my permission, Pediatric Associates may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Pediatric Associates' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Pediatric Associates reserves the right to revise its Notice of Privacy Practices and a revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer anytime.

With my permission, the office of Pediatric Associates may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

I have the right to request that Pediatric Associates restrict how it uses or discloses my 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.

By signing this, I am allowing Pediatric Associates to use and disclose my PHI for TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Patient Name Printed: _____ Date: _____

Patient Signature: _____

Patient Portal Registration

First Name: _____ Last Name: _____

Your Username: _____

(your username will be your phone number)

All calls and portal messages are prioritized based on urgency; it may take up to 48 hours to receive a response via the portal system. If you have any immediate concerns, please call the office at 603-436-7171 or 603-929-3838. If you have an emergency, please call 911

PEDIATRIC ASSOCIATES

Choose to opt in or opt out of the New Hampshire immunization/vaccination registry (18+)

Please only check **ONE** option:

☐ I choose to participate in the New Hampshire immunization/vaccination registry.

☐ I choose ***NOT*** to participate in the New Hampshire immunization/vaccination registry.

I understand that this decision will not prevent me from receiving immunizations. I understand that I may reverse my decision at any time by completing a "Reverse Previous Decision not to Participate in the New Hampshire Immunization/Vaccination Registry" form provided by my current health care provider. I understand that my immunization/vaccination information will not be released to the New Hampshire immunization/vaccination registry.

Patient name:_____ **Date:**_____

Patient's date of birth:_____ **Patient Signature:**_____

Patients who choose to decline participation in the registry are not relieved from the obligation to comply with current immunization requirements set forth in RSA 141-C:20-a and He-P 301.14.

To be completed by current health care provider:

Witness by current health care provider: _____

Initials: _____ Date:_____

As you turn 18, your healthcare privacy rights and responsibilities change. This handout explains what that means for you at Pediatric Associates as well as office information you should know.

PEDIATRIC ASSOCIATES

1. Your Medical Information Is Now Private At 18, you control access to your health records. (Unless Guardianship / Power of Attorney is in place)

- We can no longer share information with your parents or guardians unless you give us written permission.
- Without your permission, we can't discuss your care—even if they pay the bill.

2. Billing & Insurance Responsibility : Even if you're on a parent's plan, you are legally responsible for any charges, co-pays, or balances.

- Learn to read your Explanation of Benefits (EOB).
- Bring your insurance card to every visit.

3. Office Policies & Missed Appointments

- We ask that you arrive on time and cancel appointments at least 24 hours in advance. If you are 10 or more minutes late, the appointment will need to be rescheduled and is considered missed.
- *After **3 missed appointments** (no-shows) within a 12-month period, you may be **discharged** from the practice.*
- Please communicate with our office if you're having trouble keeping appointments—we're here to help.
- If you are needing to refill your prescription, please take note that your request will be processed within 48 hrs not including weekends. Call early if needed - (ex. You will run out of your prescription on the weekend)

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4. Office Appointment Availability

- Book a yearly physical to stay healthy and keep your records current. It's also required for filling out health forms or getting referrals.
- A doctor is always on call after hours for urgent issues. Call the office and leave a message with the answering service.
- If you're sick, same-day appointments are usually available during office hours. A nurse might call you first to make sure we give you the right amount of time.

➔ Reasons to be seen for a same day appointment

- ❖ Pink eye
- ❖ Ear ache
- ❖ Sore throat
- ❖ Cough
- ❖ Constipation
- ❖ Abdominal pain
- ❖ headaches
- ❖ vomiting >2 days

5. Transferring to an Adult Doctor

- When you decide to transfer your care to a new doctor, contact the office for any questions or if you need help!

Acknowledgment & Signature

I have read and understand the information in this packet. I understand that I am now legally responsible for my own healthcare decisions and medical information.

Patient Full Name (Print): _____

Patient Signature: _____ Date: _____