FOREST HILLS PEDIATRICS, LLC
7495 STATE ROAD, SUITE 335
CINCINNATI, OHIO 45255

Phone: (513) 232-5512 Fax: (513) 232-3341

Today's Date: ____________

Patient Name (Print): __________________________________ Birthdate: ____________________

AUTHORIZATION FOR RELEASE OF INFORMATION BY PATIENT OVER 18 YEARS OLD

DESCRIPTION OF "PROTECTED HEALTH INFORMATION" TO BE USED OR DISCLOSED

I understand that it is the policy of Forest Hills Pediatrics, LLC (the "Practice") to protect my privacy and to follow all state and federal privacy laws. However, I also understand that in order to involve my parents or other individuals in my medical care it will be necessary for the Practice to use/disclose some of my medical information ("Protected Health Information"). I understand that my Protected Health Information to be disclosed may include information regarding genetic testing, HIV / AIDS status, mental health diagnosis and treatment and substance abuse diagnosis and treatment, pregnancies and/or pregnancy test results and I hereby specifically authorize the Practice to disclose such information to the persons listed below:

I hereby authorize the disclosure of my Protected Health Information to the following individual(s):

Name: ____ Relationship: __________________________

Name: ____ Relationship: __________________________

PATIENT'S RIGHTS

I understand that I have the right to refuse to sign this Authorization to release my Protected Health Information. If I refuse to sign this Authorization, the Practice will in no way deny me my rights concerning treatment, payment for services, and enrollment in a health plan or eligibility for benefits.

I understand that I may revoke this Authorization at any time after I have signed it by providing the Practice Manager and the Practice's Privacy Officer, with a written statement that I wish to revoke this Authorization. My revocation of Authorization will be effective immediately and my Protected Health Information will no longer be used / disclosed pursuant to this Authorization except when medically necessary in an emergency situation.

I specifically authorize the disclosure of my Protected Health Information as set forth in this Authorization. I understand that if my Protected Health Information is disclosed, then this information may be subject to re- disclosure by the recipient and may no longer be protected by the federal patient privacy laws. For example, the recipient may request that Protected Health Information be provided to a school or camp.

This Authorization, unless I earlier revoke it, shall remain in effect for as long as I am an active patient at the Practice. Patient's Signature/Date: ____

Signature above is you agree to release information. ONLY sign below if you are REFUSING to release your medical records.

Form Presented to Patient – Patient refused to provide authorization:

Patient's Signature / Date: ____

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18 Year Old - Email

In order to communicate with our patients and families more efficiently, we are asking for an updated email address. This will only be used for important messages and we will not share your email address with anyone else.

Please fill out this form with a current email address where you would like us to send messages. Message will be sent through our patient portal.

Thank you for helping us to serve you better!

Patient's Printed Name: ___________________________________ Date of Birth: _________________

Patient's Name (Signature): ____

Email Address: ____

Phone Number (including area code): Cell ___________________ Home _____________________

Managing your healthcare has never been easier. Let us know if you would like to join our Portal and we will send you an invite. With our portal you can send view your records, request information and send messages to our clinical staff, plus so much more.

☐ Yes I would like to join the portal ☐ No I wish to decline at this time

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18 YEAR E-PRESCRIBING CONSENT FORM

E-prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

- Formulary and benefit transactions — Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

By signing this consent form you are agreeing that Forest Hills Pediatrics, LLC. can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payer's for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Forest Hills Pediatrics, LLC. to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization.

IF PATIENT IS 18 YEARS OR OLDER THEY MUST SIGN THIS CONSENT FORM. A PARENT/GRANDPARENT MAY NOT SIGN FOR THEM.

☐ Accept ☐ Decline

Print Patient Name: ____ Birthdate:____________________

Signature of Patient:

____

Today's Date_______________________

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18 YEAR - PERMISSION TO PICK UP PRESCRIPTIONS

Note: This form authorizes permission to pick up prescriptions from any persons other than Patient whose name is signed below

Name: ____ Birthdate: _________________________

_____________________________________ (Patient) I give the following individual(s) my permission to pick up any prescription or Medication (including a controlled substance). I understand that such authorization does not cover consent to major surgery or any treatment provided outside the offices of Forest Hills Pediatrics, LLC.

Name: _____________________________________ Relationship to Patient: _____________________

Name: _____________________________________ Relationship to Patient: _____________________

Check one of the following boxes:

This notice is effective only on the following date(s): _______________________________

This notice is effective from the date below until revoked.

I understand that this notice will not expire unless revoked by me in writing.

Patient – Print Name: _______________________________________

Patient – Signature: _____________________________________ Date: ________________

VERBAL CONSENT OBTAINED FROM - Patient

Name of Patient:

____

Date: ______________________________ Verbal consent effective only on the following date: ___________________________________ Name of individual documenting consent: ____ Form sent to Patient to follow-up on verbal consent on (insert date): _____________________________