Patient consent form

PROSPECT PEDIATRICS PA

Patient consent for use and disclosure of Protected Health Information

I hereby give my consent for Prospect Pediatrics PA to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The notice of privacy practices provided by Prospect Pediatrics PA describes such uses and disclosures more completely.)
I have the right to review the Notice of privacy Practices prior to signing this consent. Prospect Pediatrics PA reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Director Office Operations Prospect Pediatrics PA

With this consent, Prospect Pediatrics PA may call my home or other alternative location and leave 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 test results, among others.

With this consent, Prospect Pediatrics PA may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Prospect Pediatrics PA may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patients statements. I have the right to request that Prospect Pediatrics PA restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Prospect Pediatrics PA to use and disclose my PHI to carry out 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. If I do not sign this consent, or later revoke it, Prospect Pediatrics PA may decline to provide treatment to me.

SIGNED BY: _____ **DATE:** _____ **Relationship to Patient** _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN

Print Patient's Name: _____ **Print Name of Legal Guardian, If Applicable** _____

Patient/Guardian must be provided with a signed copy of this authorization form.

New Jersey Department of Health
Vaccine Preventable Disease Program
P.O. Box 369, Trenton, NJ 08625-0369
609-826-4860 (Fax 609-826-4866)
www.njiis.nj.gov

NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)
CONSENT TO PARTICIPATE

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

REGISTRANT INFORMATION	***PARENT/GUARDIAN INFORMATION (if NJIIS Registrant is a minor)***
Registrant Name *(Print)*	Name *(Print)*
Date of Birth	Address
Country of Birth	City, State, Zip Code
Name of Primary Health Care Provider	Relationship to Registrant

I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history.

I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3.

I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health (NJDOH). The NJDOH may be contacted at the website or telephone number listed above.

There is no cost to participate in this program.

☐Yes, I would like to participate in this program.

☐No, I do not want to participate in this program.

Signature of Registrant (or Parent/Guardian, IF Registrant under 18 Years of Age)	Date

Name of NJIIS Enrollment Site	Registry ID Number	Medical Record Number

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