Anderson Hills PEDIATRICS

7400 Jager Court, Cincinnati, OH 452301
(513) 232-8100 Fax (513) 624-3191

1126 Ohio Pike Amelia, Ohio 45102
513) 232-8100 Fax (513) 943-6154

Patient Name **(Print)**: _____ Today's Date: _____

Patient Date of Birth:_____

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 ANDERSON HILLS PEDIATRIC'S, INC. (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: _____

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

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)

Anderson Hills
PEDIATRICS

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.

Thank you for helping us to serve you better!

_____

Patient Name (Print) **Date of Birth:**

Patient's Name (Signature):

_____

Email Address:

_____

Phone Number (including area code): Cell ☐ Home ☐ Work ☐

_____

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 fill out forms, pay your bill, 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 ☐**

Anderson Hills PEDIATRICS

7400 Jager Court
Cincinnati, Ohio 45230-4380
(513) 232-8100 Fax (513) 624-3191

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Amelia, Ohio 45102-9306
(513) 232-8100 Fax (513) 943-6154

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.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

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

Understanding all of the above, I hereby provide informed consent to Anderson Hills Pediatrics, Inc. 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: _____Date of Birth:_____

Signature of Patient:

_____

Today's Date_____

Anderson Hills PEDIATRICS

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: Date of Birth:

_____ (**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 Anderson Hills Pediatrics, Inc.

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): _____

Anderson Hills PEDIATRICS

18 Year – Portal Help

Anytime, Anywhere. Managing your healthcare has never been so easy. Our Online Patient Portal facilitates better communication with our practice by providing established patients convenient and secure access 24 x 7. Using our secure portal you will be able to:

- Download for FREE – Medfusion Mobile App
- Manage your personal information
- Send messages to our clinical staff
- Manage appointments
- Review lab results
- Request a prescription refill
- Pay your bill
- Fill out forms before appointments to save you time in the office

Here are a few pointers to help you set up your portal account:

- If you have not joined, please ask staff to send you an invite or you can go to our website www.ahpediatrics.com and at the top under **Quick Links** you can **Create An Account**. Fill out all the fields that have an ***** (asterisk) by it. Please make sure you are inputting your information **ONLY.**

- **DO NOT** use parent's information.

- If you get the invite sent to you, you do not need to use the activation code – just click on the **Sign up for an account** link.
- Once you have joined the portal there are different forms to fill out to save you time in the office.

- If you are filling out an interactive form that drops right into your chart, it will not go through unless all places are answered where there is an ***** (asterisk).

- To reset your username or password, because you have forgotten one or the other, please call Eileen @232-8100 ext. 3046 or email her at emorrow@ahpediatrics.com

Please don't hesitate to call our office to assist you in any way. We hope after you join our portal that you see how convenient it is to use and it works with your busy schedule whether at home or on the go.