Patient Acknowledgement of Children's Clinic of Wyomissing Policy for the Protection of Identity Theft, HIPAA Disclosure and Other Party Authorization to treat.

Children's Clinic of Wyomissing has established an Identity Theft Prevention and Detection Program to detect and prevent or mitigate the theft of patients' financial and other identifying information. Medical identify theft is a serious problem. It can result in adverse financial consequences to the practice and our patients. In addition, if it results in incorrect information being included in a patient's medical record, it can lead to inappropriate medical care.

Responsible parties are to present our office with picture ID (driver's license, "green card," passport, employee ID card, or student ID card) as well as their insurance card which will be scanned in to our system for identification purposes and to assist with possible red flags and Identity theft.

Furthermore, in signing this form, you consent to the use and disclosure of your protected health information by Children's Clinic of Wyomissing, our staff, and our business associates strictly for the purpose of treatment, payment and health care operations.

You acknowledge you have had an opportunity to review our *Notice of Privacy Practices* prior to signing this consent. We encourage you to review our *Notice of Privacy Practice*s carefully. It provides more detail on how we may use and disclose your information.

You may request that we restrict how we use and disclose your protected health information for the purposes mentioned above. If you would like to request a restriction, please do so in writing. However, we reserve the right to deny your request. If we grant your request, we are bound by the terms of the agreement.

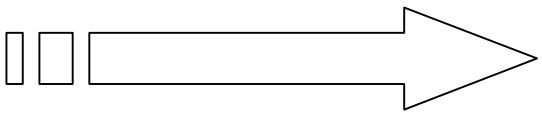
You may also revoke this consent in writing; however, information on any treatment / service provided using this or prior consents may still be used or disclosed for purposes of treatment, payment, or health care operations. Refer to the *Notice of Privacy Practices* for further information.

Please list FULL NAMES OF ALL THE CHILDREN **that are patients here:**

1._____**DOB**_____
2._____**DOB**_____
3._____**DOB**_____
4._____**DOB**_____
5._____**DOB**_____

_____ _____
Signature of Patient or Surrogate Decision Maker: Date:

Relationship to Patient/ Legal
authority *(if applicable*): _____



PLEASE LIST ALL INDIVIDUALS THAT HAVE YOUR PERMISSION TO BE INVOLVED WITH YOUR CHILD – CHILDREN HEALTH CARE.

PLEASE NOTE - if an individual's name does not appear on this list and presents your child to this office for treatment they will be asked to reschedule the appointment at which time they can provide us with your authorization for treatment.

Names:

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____
11._____

For Practice use only.

Failure to obtain consent Check the appropriate reason:

☐ Indirect Treatment Relationship ☐ Emergency treatment

☐ Substantial Communication Barrier ☐ Refusal to Sign ☐ Other

Description:

_____ _____

Practice Signature Date

Policy reviewed and Adopted October 01, 2014