La Rosa Pediatrics, Inc.

Dr. Niurka La Rosa
6900 Park Ave Suite 3
Guttenberg, NJ 07093
Phone: 201-766-0086
Fax: 201-766-0094

Patient Information

Name: _____ MI: ___ Last Name: _____

Date of Birth: _ _/ _ _/ _ _ _ _ SSN: _____-____-_____ Sex: M ☐ F ☐

Street Address: _____ City: _____

State: _____ Zip Code: _____ Email: _____

Home Phone: _____ Cell Phone: _____

Race/Ethnicity: _____ Pharmacy: _____

Parent Information

Mother's Name: _____ Date of Birth: _ _/ _ _/ _ _ _ _

Employer: _____ Employer Phone: _____

Father's Name: _____ Date of Birth: _ _/ _ _/ _ _ _ _

Employer: _____ Employer Phone: _____

In Case of Emergency:

Name: _____ Phone: _____

Relationship to Patient: _____

Insurance Information

Insurance Name: _____ ID Number:_____

Name of Insured: _____ Date of Birth _ _/ _ _/ _ _ _ _

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name _____ Date of Birth _____ Daytime Phone _____

AUTHORIZES DISCLOSURE FROM:

_____
Name of Health Provider/Organization/Individual

_____
Address

_____
Phone Number/Fax Number

TO RELEASE MEDICAL INFORMATION TO:

La Rosa Pediatrics, Inc.
6900 Park Ave Suite 3
Guttenberg, NJ 07093

PURPOSE OF THIS DISCLOSURE:

☐Transferring to New Physician
☐Disability Determination
☐Personal Use Other, please specify _____
☐Legal Investigation
☐Payment of Claim/Benefits

INFORMATION TO BE DISCLOSED:

☐Office Visit Notes
☐Laboratory Reports
☐Specific information related to: _____
☐History and Physical Exam
☐Immunization Records
☐Radiology Reports
☐All Information

☐I authorize verbal communication between _____ & _____ regarding my care and treatment at *La Rosa Pediatrics*.

YOUR RIGHTS REGARDING THIS AUTHORIZATION

Right to inspect or receive a copy of the health information to be used or disclosed: I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed.

Right to receive a copy of this authorization: I understand that if I agree to sign this authorization, which I am not required to do, I may request a signed copy of the form.

Right to refuse to sign this authorization: I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

Right to withdraw this authorization: I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact *La Rosa Pediatrics, Inc*. I am aware that my withdrawal will not be effective to uses and/or disclosures of my health information that the person(s) or organization(s) listed above have already made in reference to this authorization. *La Rosa Pediatrics, Inc.* will not condition treatment on the completion of this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient.

Further Disclosure: I understand that, if the persons or organizations I am authorizing to receive and/or use the protected health information are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

EXPIRATION DATE: This authorization is effective for one (1) year from the date signed unless otherwise indicated.

_____ _____
Patient or Legal Representative Signature/Relationship Date of Signature

DISCLOSURES REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the release of health information relating to testing, diagnosis and treatment for:

☐AIDS/HIV/STDs ☐Mental Health Care ☐Alcohol/Drug Use ☐Developmental Disabilities

_____ _____
Patient or Legal Representative Signature/Relationship Date of Signature

Revised 04/01/2013

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PARENTS/PATIENT AUTHORIZATON

Patient Name: _____ Date of Birth: _____

I _____ (Relation to patient):_____
hereby authorize La Rosa Pediatrics, Inc. staff to perform diagnostic procedures, therapy, and administration of necessary medicine while under the care of Dr. Niurka La Rosa. These authorizations also include:

- Release of information about my wellness, lab result and treatment when requested by my insurance provider.
- My responsibility for co-payments, deductibles, and any service not covered by the insurance provider.
- Payments to La Rosa Pediatrics, Inc. for services rendered by Dr. Niurka La Rosa and staff to the above patient mentioned in this form.
- Notification of any change of address/phone number/ or insurance provider.

Signature: _____ Date: _____

LA ROSA PEDIATRICS, INC.

6900 Park Ave Suite 3
Guttenberg, NJ 07093
Phone: 201-766-0086
Fax: 201-766-0094

Consent For Use and Disclosure of Personal Health Information

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy and is only to be used or shared in the minimum necessary fashion. Healthcare providers are to obtain their patient's consent for uses and disclosure of health information about the patient to carry out treatment, payment, or health care operations. By signing this consent, you understand that your physician may need to provide necessary medical information to other appropriate physicians, pharmacies, hospitals, insurance companies, laboratories, and billing agencies. Refusing to consent to the use or disclosure of your personal health information prohibits the doctor from billing for their services; scheduling your care at a hospital; or calling in a prescription to a pharmacy; or medical need. Under this law we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke any actions that have already been taken which relied on this or a previously signed consent.
If you have any objections to this form, please ask to speak with our Office Manager.

Compliance Assurance Notification for Our Patient's

The misuse of PHI has been identified as a national problem causing inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government regulations regarding HIPAA with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing service for our patients. It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI. We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

I also acknowledge that I have been provided with the "Notice Of Privacy Practices"

_____ _____ _____

Patient's Name Patient or Legal Representative Signature Date