Mansfield Pediatrics

General Consent for Treatment and HIPAA Acknowledgement

Consent For Care And Treatment: I understand that Patient, which may be defined as me, my child or a child for whom I have legal responsibility, needs medical care and treatment and I consent to such treatment at Mansfield Pediatrics. Treatment provided by medical providers, nurses and medical assistants at Mansfield Pediatrics may include evaluation and management, vaccinations, laboratory and other testing; routine medical, nursing and medical assistant care and procedures. I understand that photos and video of Patient may be taken in connection with such treatment and for operational, quality institution and agree that students may observe and participate in Patient's care and treatment under appropriate supervision.

Patient Rights: I have been provided information regarding Patient Rights and Responsibilities. This information tells me how to register a complaint or grievance that I might have relating to Patient's care at Mansfield Pediatrics.

Communicable Disease Testing: I agree that is a Mansfield Pediatrics employee or provider is exposed to Patient's blood or other bodily fluid, pursuant to Texas law, Mansfield Pediatrics may test Patient to determine the presence of communicable diseases including Human Immunodeficiency Virus (HIV) and hepatitis. I understand that these test results will be kept confidential.

Text Messaging: I understand that Mansfield Pediatrics may, in its sole discretion, remove, retain or can provide notifications to my cell phone. These tests are Do Not Reply tests for informational purposes only and are not intended as a form of two-wat communication. I acknowledge that standard text messaging rates and fees will apply, text messaging utilizes a public telephone network and full security is not guaranteed, and any person with access to my phone will be able to see these unless I take steps to protect my phone with a password or PIN. I hereby consent to Mansfield Pediatrics sending me such texts.

PROTECTED HEALTH INFORMATION

Notice of Privacy Practices: I acknowledge that I have received the Mansfield Pediatrics **Notice of Privacy Practices.** Any questions or concerns may be directed to Mansfield Pediatrics Privacy Office at the following email address: admin@mansfieldtxpediatrics.com.

Use and Disclosure of Information: I understand that Patient's medical records are confidential and cannot be disclosed without my written authorization except as authorized by law. Authorized disclosures are addressed in the Notice of Privacy Practices I have received. I understand that Patient's medical information includes past, present and future information and may include genetic testing / counseling, communicable disease information including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), records related to mental health treatment / psychiatric care and alcohol / substance abuse diagnosis or treatment (Medical information). I understand Mansfield Pediatrics must keep Patient's medical records for a time period required by law and then may dispose of them as permitted or required by law.

Consent for Electronic Sharing and Health Information Exchange: I authorize Mansfield Pediatrics to use Patient's Medical Information for Patient's treatment and related services. Unless I object below, I authorize Mansfield Pediatrics to release and send Patient's Medical Information to Patient's non-Mansfield Pediatrics health care provider electronically and / or through a Health Information Exchange (HIE), an organization that provides services to enable the electronic sharing of health-related information. Medical Information disclosed pursuant to this authorization may be used for treatment, payment and operational purposes. The Medical Information disclosed may become a part of my non-Mansfield Pediatrics health care providers' medical records and may be re-disclosed by the recipient and no longer protected by state or federal privacy laws. I understand that if Patient is also a Patient at Mansfield Pediatrics, the Medical Information from records may also be released by my signing this authorization.

I understand I can change my mind and withdraw this authorization at any time but cannot take back information that has already been electronically shared. This consent is valid unless I have withdrawn it.

I **____DO / ____DO NOT** want Patient's Medical Information shared in HIE(s). I understand, however, that if Medical Information sharing with HIE(s) is required by law, Mansfield Pediatrics must act in compliance with the law. I further understand that certain Medical Information may be shared with HIE(s) in a manner that does not identify the patient.

Patient(s):

Name	DOB
Name	DOB
Name	DOB
Name	DOB
Name	DOB

Parent/Guardian Names and Relationship:

Printed Name	Relationship to Child(ren)
Signature of Parent/Guardian	Date