Riverside Pediatrics, P.A.

You just turned 18... now what?

A guide to understanding the privacy of your medical records

What is HIPAA?

Now that you are 18 year old, you are no longer considered a minor by law. This means that you are now in control of your medical records and who has access to this information.

Signing a HIPAA (Health Insurance Portability and Accountability Act) form enables you to decide who, if anyone, can have access to your medical information and discuss your medical care with your healthcare provider.

What do we need from you?

You will need to sign a HIPAA form on or after your 18th birthday. On this form you will need to tell us who is allowed access to your health records, such as mom, dad, grandparent, etc. You do not have to allow anyone other than yourself to participate in your health care.

Participating in your own health includes requesting referrals, getting lab or x-ray results, keeping up to date on annual physicals, and requesting medication refills appropriately.

Can I change my mind?

Yes! You can make changes, deletions, or additions to your HIPAA form at any time. Remember, your parents will not be able to sign a new form for you, even if you have them listed on your HIPAA form.

I am still under my parents' insurance. Is that a problem?

That is ok, but you should know that your parents can get information through the insurance company about treatments and tests (certain tests are standard at yearly physicals) you receive. If you request us to keep your health information confidential from your parents, we cannot control what information is on your insurance EOBs. If you have questions or want to further discuss your options regarding the matter, please let us know!

When can Riverside Pediatrics give out my information without my permission?

1521 Ritchie Hwy, Suite 201, Arnold, MD 21012 Phone: 443-354-4504 Fax: 443-352-0685

There are circumstances that require us to release your medical information without your consent.

- If the providers feel you are in danger or may cause danger to yourself or others, we may contact your parents, guardians, or local authorities.
- If we receive a court order or subpoena, we may be obligated to release your medical information.
- If you are being abused or neglected, we are required to report to the appropriate agency.
- If you have a communicable disease that puts the public at risk, we are responsible for reporting it to the local health department.

This special authorization is required from you before we can share these categories of health information with any other provider outside of our practice, to a health insurer, and even to your parents.

How will you contact me?

Attached to this information sheet, you will find a "Patient Information and Disclosure Form" that we will keep in your file. This form will be used for all staff to know how we should contact you and who we can contact, if anyone at all. If you are away at college, please make note of that on your information form. You may update this form at any time.

<u>*If the consent form is left unsigned, we will not be able to disclose any of your information to anyone without your written permission*</u>

Patients Aged 18 Years or Older

Consent for Disclosure to Family Member and/or Personal Representative

Patient Name: _____ Date of Birth: _____ Race: _____

Assigned Gender at Birth: _____ Gender Identity: _____ Pronouns: _____

Current Address (If you are attending on-campus college, please provide the best mailing address):

_____

_____

Cell Number: _____ Email: _____

Do you authorize the release of sensitive health information to individuals involved in your care?

☐ Yes ☐ No

I have agreed to let certain individuals participate in discussions and decisions related to my medical care when I am not physically present, including disclosures by phone, email, or regular mail. Therefore, I hereby give permission to Riverside Pediatrics to disclose my personal medical information to the following individual(s):

Name: _____ Relationship to Patient: _____ Phone #: _____

Name: _____ Relationship to Patient: _____ Phone #: _____

I understand that this consent may be changed or revoked by me at any time by written notice to the practice.

Patient Signature: _____ Date: _____

Print Name: _____