Carteret Clinic for Adolescents and Children
3510 John Platt Drive • Morehead City, NC 28557
(252) 726-0511 • Fax: (252) 726-7441
www.carteretclinic.com

FOR OFFICE USE ONLY
rec'd by __________ / _____
completed by __________ / _____

# REQUEST FOR RELEASE AND DISCLOSURE OF MEDICAL RECORDS (PROTECTED HEALTH INFORMATION)

**Name of individual whose protected health information is to be disclosed:**

Patient Full Name: ______________________ Date of Birth: ______________________

Phone Number: ______________________ Chart Number: ______________________

Patient Address: ______________________

City, State, Zip: ______________________

**Description of information to be disclosed from treatment provided by Carteret Children's Clinic:**

- ❑ medical records for the period **(NOT to include mental health records)** __________ to __________

or ❑ the following specific portions of the medical record for the period **(NOT to include mental health records)** from __________ to __________:

- ❑ immunization records
- ❑ history and physicals
- ❑ lab results, x-rays, diagnostic test results
- ❑ other __________
- ❑ educational testing results (CCC only)
- ❑ developmental/psychological information (CCC only)
- ❑ medication sheet, medication information
- ❑ CCA comprehensive clinical assessment

You have the right to exclude information about substance abuse, and HIV/AIDS-related information. This information is protected by Federal confidentiality rules (42 CFR part 2 and 130-A143). The rules prohibit us from making any further disclosure of information unless further disclosure is expressly permitted by your written consent.

**YES, DISCLOSE THIS INFORMATION**: I give consent to release information about **HIV/AIDS.**

Signature: ______________________ Date: ______________________

**YES, DISCLOSE THIS INFORMATION**: I give consent to release information about **substance abuse.**

Signature: ______________________ Date: ______________________

**Name of facility disclosing information:**
I hereby authorize the following organization/person to **release** protected health information:

Name: ______________________

Address: ______________________

City, State Zip: ______________________

Phone Number: ______________________

**Name of facility/person to receive protected health information:**

Name: Carteret Clinic for Adolescents and Children

Address: 3510 John Platt Drive

City, State Zip: Morehead City, NC 28557

Phone Number: 252-726-0511

FAX: 252-726-7441

**Purpose of Disclosure**

- ❑ continuing medical care
- ❑ referral
- ❑ legal proceedings (name of attorney)
- ❑ other ______________________
- ❑ personal use
- ❑ insurance request

I understand that I may **revoke** this release at any time, in writing, but the request shall remain valid until revoked or upon the **expiration** of 365 days. The revocation may not be effective to the extent that action has already been taken on this authorization. I understand that Carteret Children's Clinic assumes no responsibility for the use or misuse by others of my health information and I release them from all legal liability that may arise from this authorization. **There may be a charge to produce medical records.**

Parent/legal guardian signature: ______________________ Date: __________

Please Print: ______________________ Relationship to Patient: __________

Witness: ______________________ Date: __________

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# Welcome

## Tell Us About Your Child

Today's Date: __________ Home Phone #: (____) __________ Child's SS #: __________ Race: __________

Child's Name: ______________________________ Child's Birthdate: ____ / ____ / ____ Child's Age: ______
Last First MI

Nickname: __________ ☐ Male ☐ Female School: __________ Grade: ______

Child's Home Address: ______________________________
Street City State Zip

Your Name: __________ Relation to Patient: __________

Do you have legal custody of this child? ☐ Yes ☐ No ☐ Shared Is the child in a foster home? ☐ Yes ☐ No

Whom may we thank for referring you? __________ Other siblings seen by us: __________

**Emergency Contact (Neighbor or relative not living with you)**

Name: __________ Relation to Patient: ______ Home Ph #: (____) ______ Work Ph #: (____) ______

Address: ______________________________
Street City State Zip

**Previous Physician**

Name: __________ Address: __________ Ph #: (____) ______

## Parent's Information

Parent's Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Remarried ☐ Single

☐ **Mother** ☐ Step Mother ☐ Guardian Birthdate ____ / ____ / ____ Home Ph #: (____) ______ Work Ph #: (____) ______

Full Name: ______________________________ Social Security #: __________

Address: ______________________________
Street City State Zip

Employer: ______________________________ Length of Employment: __________

☐ **Father** ☐ Step Father ☐ Guardian Birthdate ____ / ____ / ____ Home Ph #: (____) ______ Work Ph #: (____) ______

Full Name: ______________________________ Social Security #: __________

Address: ______________________________
Street City State Zip

Employer: ______________________________ Length of Employment: __________

## Child's Family History

| | Age, if Living | Age at Death & Cause of Death |
|---|---|---|
| Mother | | |
| Father | | |
| Siblings (circle one) | Age, if Living | Age at Death & Cause of Death |
| Male / Female | | |
| Male / Female | | |
| Male / Female | | |
| Male / Female | | |

**Family Medical Problems**

Please identify any medical problems blood relatives have or ever have had.

| Condition | Yes | No | Family Member (s) |
|---|---|---|---|
| Birth Defects | ☐ | ☐ | |
| Genetic Defects | ☐ | ☐ | |
| Mental Retardation | ☐ | ☐ | |
| Allergies | ☐ | ☐ | |
| Lung Disease | ☐ | ☐ | |
| Asthma | ☐ | ☐ | |
| Bone / Joint Disorders | ☐ | ☐ | |

| Condition | Yes | No | Family Member(s) |
|---|---|---|---|
| Rheumatic Arthritis | ☐ | ☐ | |
| Muscle Disorders | ☐ | ☐ | |
| Skin Disease | ☐ | ☐ | |
| Eye or Ear Disorders | ☐ | ☐ | |
| Cancer | ☐ | ☐ | |
| Diabetes | ☐ | ☐ | |
| Thyroid Disease | ☐ | ☐ | |
| Heart Disease / Problems | ☐ | ☐ | |
| Anemia / Blood Disorders | ☐ | ☐ | |
| High Blood Pressure | ☐ | ☐ | |
| Kidney Disease / Problems | ☐ | ☐ | |
| Rheumatic Fever | ☐ | ☐ | |
| Tuberculosis (TB) | ☐ | ☐ | |
| Seizures / Convulsions | ☐ | ☐ | |
| Mental Disease / Disorders | ☐ | ☐ | |
| Venereal Disease | ☐ | ☐ | |
| HIV / AIDS | ☐ | ☐ | |
| Other ______ | ☐ | ☐ | |

# Child's Health History

**Has your child ever had:**

| | Yes | No |
|---|---|---|
| Measles (10 day) | ☐ | ☐ |
| Rubella (3 day measles) | ☐ | ☐ |
| Mumps | ☐ | ☐ |
| Chicken pox | ☐ | ☐ |
| Whooping cough | ☐ | ☐ |
| Rheumatic fever | ☐ | ☐ |
| Hepatitis (liver disorders) | ☐ | ☐ |
| Bronchitis or chronic cough | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Pneumonia | ☐ | ☐ |
| Anemia / blood disorders | ☐ | ☐ |
| Difficulty talking | ☐ | ☐ |
| Stuttering | ☐ | ☐ |
| **Eyes** | | |
| Crossed or wandering eyes | ☐ | ☐ |
| Vision problems | ☐ | ☐ |
| Eye irritation | ☐ | ☐ |
| Frequent headaches | ☐ | ☐ |
| **Ears** | | |
| Frequent ear infections | ☐ | ☐ |
| Hearing problems | ☐ | ☐ |
| **Mouth** | | |
| Been to a dentist | ☐ | ☐ |
| Date of last visit ______________ | | |
| Dental problems | ☐ | ☐ |
| Sores in mouth/gums | ☐ | ☐ |

| **Nose and throat** | Yes | No |
|---|---|---|
| Frequent sore throats | ☐ | ☐ |
| Persistent hoarseness | ☐ | ☐ |
| Frequent nose bleeds | ☐ | ☐ |
| Frequent stuffed up nose | ☐ | ☐ |
| Frequent tonsil infections | ☐ | ☐ |
| Tendency to breath through his (her) mouth | ☐ | ☐ |
| **Lungs / Asthma** | | |
| Difficulty breathing | ☐ | ☐ |
| Tendency to wheeze | ☐ | ☐ |
| Repeated coughing spells | ☐ | ☐ |
| **Heart** | | |
| Shortness of breath | ☐ | ☐ |
| To be propped up in bed to breathe comfortably | ☐ | ☐ |
| To squat down to breathe when playing | ☐ | ☐ |
| Nervous System | ☐ | ☐ |
| Dizzy or fainting spells | ☐ | ☐ |
| Periods of confusion or disorientation | ☐ | ☐ |
| Convulsions, seizures | ☐ | ☐ |
| Tremors ( "the shakes" ) | ☐ | ☐ |
| Difficulty walking, balancing or handling objects | ☐ | ☐ |

| **Musculoskeletal system** | Yes | No |
|---|---|---|
| Painful or swollen joints | ☐ | ☐ |
| Sprains, dislocations, or broken bones | ☐ | ☐ |
| Posture problems | ☐ | ☐ |
| Muscle coordination or strength problems | ☐ | ☐ |
| **Skin** | | |
| Eczema / skin problems | ☐ | ☐ |
| Slow healing bruises | ☐ | ☐ |
| Persistent rashes | ☐ | ☐ |
| Digestive system | ☐ | ☐ |
| Frequent stomach aches | ☐ | ☐ |
| Frequent diarrhea | ☐ | ☐ |
| Frequent constipation | ☐ | ☐ |
| Frequent nausea or vomiting | ☐ | ☐ |
| Worms | ☐ | ☐ |
| Bloody or very dark stools | ☐ | ☐ |
| Special food restrictions | ☐ | ☐ |
| Genitourinary system | ☐ | ☐ |
| A urination problem | ☐ | ☐ |
| Painful, burning urination | ☐ | ☐ |
| Blood in urine | ☐ | ☐ |
| Unusual urine odor | ☐ | ☐ |
| Persistent diaper rash | ☐ | ☐ |
| Bed-wetting problems | ☐ | ☐ |
| A discharge from vagina or penis | ☐ | ☐ |

**General**

| Has your child ever: | Yes | No |
|---|---|---|
| Had excessive thirst | ☐ | ☐ |
| Had marked increase or decrease in appetite | ☐ | ☐ |
| Had unusual sensitivity to heat or cold | ☐ | ☐ |
| Eaten paint, dirt, or plaster | ☐ | ☐ |
| Been persistently tired | ☐ | ☐ |
| Had unusually slow healing scrapes, cuts, or wounds | ☐ | ☐ |
| Had a recurrent fever | ☐ | ☐ |
| **Within the past six months, has your child:** | | |
| Had frequent nightmares | ☐ | ☐ |
| Been unusually nervous or high strung | ☐ | ☐ |
| Had extreme mood swings | ☐ | ☐ |
| Been unusually disobedient | ☐ | ☐ |
| Been having problems at school or with friends | ☐ | ☐ |

Other ______________________

______________________

______________________

Describe any problems ______________

______________________

______________________

## PREGNANCY & BIRTH

Is child adopted? ☐ Yes ☐ No Child's age at adoption: ______________ Mother's age at pregnancy: ______________

Any illness during pregnancy? ☐ Yes ☐ No Describe any illnesses: ______________________

Medications taken during pregnancy: ______________________

Smoking / alcohol / street drugs / during pregnancy? (specify) ______________________

Was the baby early / late / on time? ______________ Type of delivery? C-Section / Vaginal ______________

Baby's birth weight: ______________ Length: ______________ Complications? ______________

Problems with baby at birth (breathing / jaundice / other) ? ______________________

## DEVELOPMENT & BEHAVIOR

Please indicate age at which this child:

Sate alone: ____________ Walked: ____________ Used sentences: ____________ Toilet trained: ____________ Bicycled: ____________

Development compared to other children: ______________________

Grade in school: ______________ Problems in school? ______________________

Getting along with other children? ______________ Behavior Problems? ______________________

Bad habits? ______________________ Bedwetting? ______________________

Nail biting? ______________________ Trouble Sleeping? ______________________

Hobbies (sports, social activities)? ______________________

## FEEDING & NUTRITION

Food allergies: ______________________ Appetite usually good? ______________________

Colic or feeding problems during the first 3 months? ______________ Breast Fed? ______________ Number of months breast fed? ________

Formula? ______________ Brand ______________ City or Well water? ______________

Vitamins? ______________ Brand ______________ Taking Fluoride? ______________

Special Diet? ______________________

## PAST MEDICAL HISTORY

Medications taken on a regular basis? ______________________

______________________

Immunizations up to date? ______________ Do you have a shot record? ______________ (if no, please request from previous doctor)

Hospitalizations (when / where / why)? ______________________

Serious injuries (when / where / what)? ______________________

Is child on nebulizer? ______________ Is child on monitor? ______________

## ALLERGY ALERT

Please list all allergies, include the substance and your child's reaction to it: ______________________

______________________

Parent Signature: ______________________ Date: ______________

Print Name: ______________________ Nurse Signature: ______________ Date: ______________

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# FAMILY INFORMATION SHEET

**CHILD BEING SEEN TODAY** (if 18 years old or older, please list your phone #)

Child's Full Name: ______________________________________________
First / Middle / Last / Suffix / Phone #

Child's Mailing Address: ______________________________________________
Street / City / State / Zip

Date of Birth: ____________________ Social Sec. No.: ____________________ Gender: Male / Female

**Ethnicity:** Non-Hispanic / Hispanic / Unknown **Race:** Amer. Indian or Eskimo / Asian / Black / Hawaiian or Pac Isl / White **Primary Language:** __________

**Lives with:** ☐ Both Natural Parents ☐ Mother ☐ Father ☐ Other (step- or grand parents, etc) ____________________

Biological Father Name ____________________ Biological Mother Name ____________________

Billing statements will be sent to Custodial Parent at above address unless otherwise specified and agreed upon ____________________

Primary Insurance Co.: ____________________ Secondary Insurance Co.: ____________________

Father/Legal Guardian: **FULL Name** ____________________
First / Middle / Last / Suffix

Social Sec. No.: ____________________

Date of Birth: ____________________

Mailing Address: ____________________

Physical Address: ____________________

City; State; Zip: ____________________

Phone (H): __________ (W): __________

Mobile: __________ (other) __________

E-Mail: ____________________

Employer / Occupation: ____________________

Mother/Legal Guardian: **FULL Name** ____________________
First / Middle / Last

Soc. Sec. No.: ____________________

Date of Birth: ____________________

Mailing Address: ____________________

Physical Address: ____________________

City; State; Zip: ____________________

Phone (H): __________ (W): __________

Mobile: __________ (other) __________

E-Mail: ____________________

Employer / Occupation: ____________________

**Please list any step parents or others involved in this child's care**

Name: ____________________ Relationship: ____________________ Phone: ____________________

Name: ____________________ Relationship: ____________________ Phone: ____________________

***Please complete this section if there is a court ordered custody agreement. We will need a copy of this documentation.***

If parents are separated, divorced or not married, who has custody? FATHER / MOTHER / JOINT / OTHER ____________________

Are there any **LEGAL** restrictions for either parent that would keep them from consenting to medical treatment for child? YES or NO

(If yes please explain) ____________________

**Emergency Contacts (local and NOT a parent)**

Name: ____________________ Relationship: ____________________ Phone: ____________________

Name: ____________________ Relationship: ____________________ Phone: ____________________

Signature: ____________________ Relationship to patient: ____________________

Print Name: ____________________ Date: ____________________

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# FAMILY INFORMATION SHEET Part 2

## Other Children Living in Same Household

**OTHER CHILD LIVING IN SAME HOUSEHOLD**

Child's Full Name: ______________________________________________
First Middle Last Suffix

Date of Birth: ____________________ Social Sec. No.: ____________________ Gender: Male / Female

**Ethnicity:** Non-Hispanic / Hispanic / Unknown **Race:** Amer. Indian or Eskimo / Asian / Black / Hawaiian or Pac Isl / White **Primary Language:** ____________

**Lives with:** ☐ Both Natural Parents ☐ Mother ☐ Father ☐ Other (step- or grand parents, etc) ____________________

Biological Father Name: ____________________ Biological Mother Name: ____________________

Billing statements will be sent to Custodial Parent at above address unless otherwise specified and agreed upon ____________________

Primary Insurance Co.: ____________________ Secondary Insurance Co.: ____________________

**OTHER CHILD LIVING IN SAME HOUSEHOLD**

Child's Full Name: ______________________________________________
First Middle Last Suffix

Date of Birth: ____________________ Social Sec. No.: ____________________ Gender: Male / Female

**Ethnicity:** Non-Hispanic / Hispanic / Unknown **Race:** Amer. Indian or Eskimo / Asian / Black / Hawaiian or Pac Isl / White **Primary Language:** ____________

**Lives with:** ☐ Both Natural Parents ☐ Mother ☐ Father ☐ Other (step- or grand parents, etc) ____________________

Biological Father Name: ____________________ Biological Mother Name: ____________________

Billing statements will be sent to Custodial Parent at above address unless otherwise specified and agreed upon ____________________

Primary Insurance Co.: ____________________ Secondary Insurance Co.: ____________________

**OTHER CHILD LIVING IN SAME HOUSEHOLD**

Child's Full Name: ______________________________________________
First Middle Last Suffix

Date of Birth: ____________________ Social Sec. No.: ____________________ Gender: Male / Female

**Ethnicity:** Non-Hispanic / Hispanic / Unknown **Race:** Amer. Indian or Eskimo / Asian / Black / Hawaiian or Pac Isl / White **Primary Language:** ____________

**Lives with:** ☐ Both Natural Parents ☐ Mother ☐ Father ☐ Other (step- or grand parents, etc) ____________________

Biological Father Name: ____________________ Biological Mother Name: ____________________

Billing statements will be sent to Custodial Parent at above address unless otherwise specified and agreed upon ____________________

Primary Insurance Co.: ____________________ Secondary Insurance Co.: ____________________

Signature: ____________________ Relationship to patient: ____________________

Print Name: ____________________ Date: ____________________

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# FINANCIAL POLICY AND AGREEMENT TO PAY FOR TREATMENT

We are pleased that you have chosen us to provide health care for your child. In order to avoid any misunderstanding, we ask that you carefully read and sign this financial statement. If you have any questions, please do not hesitate to ask one of our staff members.

1. The person who brings the child to our office is expected to pay for that day's visit. We accept cash, personal check, and Mastercard / Visa. All copayments are required to be paid at the time of service. For patients not covered by insurance (self pay) we offer a **25% discount** if the charges are **paid in full** at the time of service. There are times when it is not possible to pay in full at the time of each visit, and in such cases, you must speak with the account manager to discuss payment options.

2. We are contracted with Blue Cross/Blue Shield, Medcost, Cigna, Aetna, United Healthcare and Atlantic Integrated Health. We are in network with Tricare and are Tricare Prime managers for those patients assigned to our clinic. Mental Health services vary between insurance companies, so please check with your insurance company for detailed information regarding what is covered under your policy. We also accept patients covered by NC Medicaid and NC Health Choice. We will file your insurance claims under these carriers as well as most other major insurance carriers as a courtesy. You must verify your insurance coverage at every visit. We will be happy to assist you in filing your own insurance claims with your carrier if necessary.

3. If your child is covered by Medicaid, you must present the card to the receptionist prior to each visit to our office. Without proof of coverage, we cannot perform services under the Medicaid program, and you will be responsible for payment of all charges. If the child is covered by other insurance in addition to Medicaid, it is VERY important that we get this information. If another physician is listed as the Carolina Access provider, they are required to authorize any services we provide at our clinic. Our insurance department will discuss any questions you may have regarding insurance coverage and our policies.

4. It is important that you understand that our financial relationship is with you, not your insurance company. For certain carriers, we file claims as a courtesy, however, the parent or responsible party is ultimately responsible for the bill. It is always your responsibility to understand the coverage your insurance program provides and its referral process. It is your responsibility to secure proper authorization if your plan requires prior approval to make an appointment with us. Visitors should be especially aware of this if they are members of an HMO or preferred care plan. If your insurer refuses to pay for services or you do not have authorization for our services, you are responsible for non-covered charges.

5. The person who brings the child to the office is expected to make a payment on that day of service. However, when a relative or other caretaker brings the child, the charges can be applied to that child's account if previous arrangements have been made and the account is in good standing. In cases where the parents are separated or divorced, the parent bringing the child to our office is responsible for payment. Only one parent can be billed, therefore both parents have the responsibility to communicate with each other to ensure that their child's account does not become delinquent.

6. Collection procedures: Established accounts will receive monthly statements reflecting the balance due on the account after insurance has been filed and all insurance payments have been received. Should no payment be received on the account for 60 days, additional mail and phone reminders will be made in an attempt to collect the debt. Our policy is to help those with outstanding balances understand their account and reach an agreement on payment options. After 90 days of nonpayment or if a payment agreement is breached, an unpaid account may be turned over to an outside collection agency with an additional 35% fee to cover costs involved in the collection process.

7. A $25 charge is made for all checks returned for non-sufficient funds.

8. Overpayments on your account will be refunded within 90 days of overpayment, or upon request.

I have read the above financial policy of Carteret Clinic for Adolescents and Children and understand completely my responsibilities under this policy. I agree to pay all charges submitted by this office during the course of treatment.

Responsible party (please print): ______________________________ Signature: ____________________

Patient(s) Name: ____________________________________________

Date(s) of Birth: ____________________________________________

Today's Date: ____________________________________________

EFFECTIVE APRIL 1, 2016

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# AUTHORIZATIONS

Please read each authorization section carefully and sign at the bottom. If you have any questions, please ask for clarification. One must be signed for EACH patient. The following authorizations shall remain in effect until specifically revoked in writing.

Full Name of Patient (please print):______________________________________________________Date of Birth ____________________

**Certification of Authority to Consent**
I certify that I am the Patient or the legal guardian of the Patient and, if the Patient is a minor, I certify that I am a parent of the minor Patient, or if living separate and apart or divorced, the custodial parent or authorized non-custodial parent of the minor Patient (collectively the "Patient or Legal Guardian") and that I have full authority to give legal and valid consent to the following for the Patient.

**Consent for Treatment**
I, being the parent or guardian of the Patient, who is a minor child, do hereby request and authorize the staff of Carteret Children's Clinic to perform any and all necessary services for the Patient, including but not limited to immunizations, labwork, and the administration of anesthetics which are deemed advisable by the provider, whether or not I am present at the actual appointment when the treatment is rendered. Any photos taken of the patient will be used for purposes of identification in the medical record. I understand that I have the right to refuse treatment without threat or termination of services except as outlined in the statute ***GS122C-57(d).*** Consent for treatment may be withdrawn at any time, in writing.

**Release and Statement to Permit Payment of Private Insurance Benefits to Provider**
The undersigned Patient or Legal Guardian hereby authorizes Carteret Children's Clinic, its agents and employees to release and disclose all or any part of the Patient's medical records to any entity which is, or may be, liable for all or part of the provider's charges for services rendered or items supplied to the Patient. The undersigned Patient or Legal Guardian authorizes the release and disclosure of any and all medical records to any other entity, including, but not limited to, referring physicians, hospitals, or other health care providers which may be of assistance, in the opinion of this office, in providing for the treatment of the Patient.

The undersigned Patient or Legal Guardian authorizes the release of records necessary to assist in the reimbursement of benefits to which the Patient or Legal Guardian may be entitled in connection with services rendered or items supplied to the Patient by Carteret Children's Clinic and authorizes this office and/or its employees to release, via fax, electronic or paper format, medical records which are needed in order to provide the Patient with the most appropriate medical care.

The undersigned Patient or Legal Guardian authorizes and requests that payment of any third-party or insurance company benefits be made to Carteret Children's Clinic for any services or items supplied to the Patient. The signatures furnished below shall suffice for all insurance forms on a continuing basis.

**Consent for Protected Health Information Communication**
The undersigned Patient or Legal Guardian hereby authorizes Carteret Children's Clinic to communicate with me by my preferred method as well as phone, voice mail, text, postal mail, email and fax regarding any items that assist the practice in carrying out TPO, such as appointment reminders, insurance and billing issues, and any issues pertaining to the Patient's clinical care, including laboratory results among others. For email, fax, and/or text communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email, fax and/or text communication as selected. **If I authorize only my preferred method of communication, I will notify the practice and complete the Communication Restriction form.** I have the right to request that Carteret Children's Clinic restrict how it uses or discloses the Patient's PHI to carry out TPO, however, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

**Consent for Use and Disclosure of Protected Health Information**
The undersigned Patient or Legal Guardian hereby authorizes Carteret Children's Clinic to use and disclose the Patient's protected health information (PHI) to carry out treatment, payment, and healthcare operations (TPO). I have been given a copy of and had the opportunity to review Carteret Children's Clinic Notice of Privacy Practices and Patient Rights and Responsibilities prior to signing this consent. I have been notified that release or disclosure of PHI may only occur with a valid consent unless it is an emergency or for other exceptions as detailed in the ***General Statues or in 45CFR 164.512 of HIPAA.***

**Patient Rights**
The undersigned Patient or Legal Guardian has been informed of their right to treatment, including access to medical care and habilitation, regardless of age, or degree of MH/DD/SA disability. I have been informed and given opportunity to review the Disability Rights NC and Patient Rights which are visibly posted in the patient waiting room.

Treatment plans for counseling services will be reviewed and provided in writing at the follow-up appointment by the counselor within 15 business days. Clinical summaries from a medical visit can be obtained via the patient portal within 3 business days.

*(continued on other side)*

**SIGNATURE REQUIRED ON REVERSE**

**Revocation of Consent**

The undersigned Patient or Legal Guardian has been informed of their right to revoke consent in writing except to the extent that the already made disclosures in reliance upon prior consent. I may inspect the PHI to be disclosed as described in the document. Informa disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or have the right to refuse to sign this authorization and that treatment of the patient will not be conditioned on signing.

**I have read and understand the above certifications, authorizations, consents and rights. I have had a chance to ask any ques these items and all my questions were answered to my satisfaction.**

**Signature of Parent or Legal Guardian:** ______________________ **Date:** ____________

**Please print name in full:** ______________________ **Relationship to patient:** ____________