VIVA PEDIATRICS

By Your Side... From Crawling to Flying

MEDICAL RELEASE AUTHORIZATION (HIPAA RELEASE):

I hereby authorize the following people to authorize evaluation, medical treatment / Immunizations and to receive any and all test results, to include general medical condition and your diagnosis (including treatments and billing). I also understand that information relevant to HIV testing and / or AIDS related diagnosis may be contained in this information. This list also includes people who can be reached in an emergency situation. The duration of this consent is indefinite and continued until revoked in writing.

Print Name	Relationship	Phone Number
Print Name	Relationship	Phone Number
Print Name	Relationship	Phone Number
Print Name	Relationship	Phone Number
Print Name	Relationship	Phone Number

Please indicate if a confidential message can be left on your telephone, cell phone voicemail or answering machine. ___ YES ___ NO

___ I DO authorize anyone listed above to receive any test results or medical history
___ I DO NOT authorize anyone listed above to receive any test results or medical history

_____ _____

Print Name of Guarantor: Signature of Guarantor:

_____ _____

Print Patient Name: DOB: Relationship to Patient:

_____

Date:

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E-PRESCRIBING / MEDICATION HISTORY CONSENT FORM:

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-prescribing program. These include:

* **Formulary and benefit transaction** – gives the prescriber information about which drugs are covered by the drug benefit plan.
* **Medication history transaction**- Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
* **Fill status notification** – the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent from you are agreeing that VIVA Pediatrics can request and use your prescription medication history from other healthcare providers and / or thirds party pharmacy benefit payors for treatment purposes. The duration of this consent is indefinite and continued until revoked in writing.

Understanding all of the above, I hereby provide informed consent to VIVA Pediatrics to enroll me in the e-Prescribing Program. I have had the chance to ask questions and all of my questions have been answer to my satisfaction.

_____ _____

Print Name of Guarantor: Signature of Guarantor:

_____ _____

Print Patient Name: DOB: Relationship to Patient:

_____

Date:

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AUTHORIZATION AND CONSENT AGREEMENTS:

ACKNOWLEDGEMENT OF HIPAA

I have reviewed a copy of the "Notice of Privacy Practices" from VIVA Pediatrics, which explains how my child's medical information will be used and disclosed. I understand that I can request a copy of the notice at anytime and that I have the right to review the notice prior to signing this consent.

CONSENT TO TREAT

I hereby authorize the physicians and employees of VIVA Pediatrics, to render medical evaluations and care of the patient. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patients (s) will be provided medical care except in the case of an emergency.

Keeping information private is important to us and by default we will only disclose information related to the patient's Billing Account and Medical Conditions to the parent or legal guardian. All treatment and medical information will be discussed with **both biological parents** unless otherwise specified.

I have read and understand VIVA Pediatrics Authorization and Consent Agreements. The duration of this consent is indefinite and continued until revoked in writing.

_____ _____

Print Name of Guarantor: Signature of Guarantor:

_____ _____

Print Patient Name: DOB: Relationship to Patient:

_____

Date: