HPC REG CONSENTS Hillsboro Pediatric Clinic, LLC

PATIENT INFORMATION				
Last Name:	First:	Middle:	☐ Male ☐ Female	Birth Date:

THE FOLLOWING CONSENTS AND PERMISSIONS APPLY TO ME AND MY CHILD

Pharmacy: I hereby authorize Hillsboro Pediatric Clinic LLC (HPC) to electronically send prescriptions to a participating pharmacy of my choice. HPC may electronically receive information regarding my and/or my child's prescription history, drug interactions, prior authorization requirements or required substitutions.

Pharmacy Name: _____ **Location:** _____

Contact Preferences: I would prefer that HPC use the preferred contact method indicated below when confirming appointments:

☐ Phone ☐ Email ☐ Text

Patient Centered Primary Care Home: As a Patient Centered Primary Care Home ("Medical Home") HPC is committed to providing the highest quality patient centered care. HPC care is delivered by a team of health care professionals including Physicians and Nurse Practitioners, Registered Nurses, Medical Assistants and other skilled staff. I will be encouraged and supported as I am involved in my and/or my child's care. The goal is to ensure that my and/or my child's healthcare needs are coordinated for the best possible health outcome. For more details I recognize that I have access to a Medical Home Brochure.

Authorization to Treat: By my signature below I give permission to HPC to treat me and/or my child. By signing this form, I am consenting to the Clinic's use and disclosure of my protected health information to carry out treatment, payment or healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Hillsboro Pediatric Clinic LLC may decline to provide treatment to the patient listed above.

I ATTEST TO THE ABOVE:

Patient or Legal Guardian Name: _____ **Relationship to patient:** _____

Signature: _____ **Date:** _____

Notice of Privacy Practices: I also acknowledge that I have access to a complete copy of HPC's Notice of Privacy Practices, which describes in detail how medical information about me and/or my child may be used and disclosed, and how I can get access to this information.

I ATTEST TO THE ABOVE:

Signature: _____ **Date:** _____

☐ Patient or responsible party refused to sign the acknowledgement. _____ _____