Past Medical History (page 1)

Pediatric Health Care Alliance, P.A.
Your Child's Medical Home™

Patient Name:_____ D.O.B.:_____

General Health

☐ Premature birth	☐ Congenital abnormalies (e.g. cleft palate, heart defect)
☐ Birth weight less than 5.5 lbs.	☐ Hospitalizations

Allergies

☐ None	☐ Food allergies (e.g. peanuts, eggs milk)
☐ Environmental allergies (e.g. pollen, dust)	☐ Medication allergies (e.g. antibiotics, aspirin)
☐ Other allergies (e.g. insect stings, latex)	☐

ENT

☐ None	☐ Hearing problems
☐ Recurrent ear infections	☐ Tongue tied
☐ Enlarged tonsils	☐ Recurrent sinusitis
☐ Sleep apnea	☐ Enlarged adenoids

Dermatology

☐ None	☐ Eczema
☐ Acne	☐ Psoriasis

Developmental

☐ None	☐ Developmental delay (e.g. speech, motor skills)
☐ Learninng disabilities or difficulties	☐ Attention Deficit Hyperativity Disorder (ADHD)
☐ Autism Spectrum Disorder (ASD)	☐ Speech Delay
☐ Language Delay	

Respiratory History

☐ None	☐ Asthma
☐ Wheezing	☐ Chronic cough
☐ Bronchitis	☐ Pneumonia
☐ Cystic fibrosis	☐ Inhaler or nebulizer

Cardiovascular History

☐ None	☐ Heart murmer
☐ Congenital heart disease	☐ High blood pressure (hypertension)
☐ Arrythmias	☐ Syncope (fainting)

Past Medical History (page 2)

Patient Name:_____ D.O.B.:_____

Gastrointesitinal History

☐ None	☐ Gatroesophageal reflux (GERD)
☐ Constipation	☐ Celiac disease
☐ Food intolerances or sensitivities	☐ Gallbladder disease
☐ Inflammatory bowel disease	☐ Hepatitis

Muskuloskeletal History

☐ None	☐ Fractures or broken bones
☐ Scoliosis	☐ Juvenile arthritis

Endocrine History

☐ None	☐ Diabetes type 1
☐ Diabetes type 2	☐ Thyroid disorders
☐ Growth hormone deficiencies	☐ Adrenal disorders
☐ Obesity	

Neurological History

☐ None	☐ Seizures (e.g. febrile or other)
☐ Headaches	☐ Migraines
☐ Head injury	☐ Concussion
☐ Fainting or loss of conciousness	☐ Tics or other movement disorders
☐ Sleep disorders (e.g. sleep apnea, insomnia)	

Other History

☐	☐
☐	☐

Completed by (printed name):_____Relationship to patient:_____

Signature:_____ Date:_____

Family History

Pediatric Health Care Alliance, P.A.
Your Child's Medical Home™

Patient Name:_____ D.O.B.:_____

Does the patient's Mother , Father or sibling(s) have any of the following history.				
Skin	☐ Eczema	☐ Psoriasis	☐ Ichthyosis	
Eyes	☐ Blindness	☐ Cataracts	☐ Lazy eye	
Ears	☐ Deafness	☐ Ear infections	☐ Deformities	
Nose/ Throat	☐ Sinus problems	☐ Tonsillitis	☐ Lack of sense of smell	
Mouth	☐ Cleft palate	☐ Cleft lip		
Glands	☐ Thyroid trouble	☐ Diabetes (adult)	☐ Diabetes (juvenile)	
Lungs	☐ Asthma	☐ Cystic fibrosis		
Heart	☐ Murmers	☐ Heart attacks	☐ Congenital abnormalities	☐ High blood pressure
Stomach/ Bowel	☐ Ulcers	☐ Colitis	☐ Lactose intolerance	
Kidney/Bladder	☐ Congenital abnormalities	☐ Infections	☐ Kidney stones	
Bone/ Joint Disease	☐ Rhematoid artritis	☐ Osteoarthritis	☐ Osteogenesis imperfecta	
Neurological Problems	☐ Seizures	☐ Paralysis	☐ Strokes	
Psychiatric	☐ Schizophrenia	☐ Manic depresssive (bipolar disorder)		
Cancer Type				
Developmental Problems				
Other Probems				

Completed by (printed name):_____ Relationship to patient:_____

Signature:_____ Date:_____

Surgical History

Pediatric Health Care Alliance, P.A.
Your Child's Medical Home

Patient Name:_____ D.O.B.:_____

General Surgery

☐ Inguinal hernia repair	☐ Umbilical hernia repair
☐ Appendectomy (for appendicitis)	☐ Repair of pyloric stenosis
☐ Excision of skin lesion/cysts	☐ Foreign body removal (airway, GI tract, ear, nose)

Gastrointestinal Surgery

☐ Ladd's procedure (for malrotation)	☐ Fundoplication (for GERD)
☐ Bowel resection	☐ Anorectal malformation repair
☐ Colostomy/ ileostomy (creation or closure)	

Urologic Surgery

☐ Circumcision	☐ Orchidoplexy (for undescendeed testicle)
☐ Orchiectomy (for removal of testicle)	☐ Vesicoureteral reflux surgery
☐ Hypospadius repair	☐ Posterior urethral valve ablation

ENT Surgery

☐ Tonsiliectomy	☐ Adenoidectomy
☐ Ear tubes	☐ Choanal atresia repair
☐ Laryngomalacia surgery	☐ Endoscopic sinus surgery

Cardiovascular Surgey

☐ Patent ductus arteriosus ligation (PDA)	☐ Atrial septal defect (ASD)
☐ Ventricular septal defect (VSD)	☐ Tetrology of fallot repair
☐ Coarctation of the aorta repair	☐ Pectus excavatum repair

Neurosurgical Procedures

☐ Ventriculoperitoneal (VP) shunt placement for hydrocephalus	☐ Craniosynostosis repair
☐ Tethered cord release	☐ Myleomeningocele closure (for spina bifida)

Orthopedic Surgery

☐ Clubfoot correction	☐ Fracture repair
☐ Scoiliosis surgery	☐

Other

☐	☐
☐	☐

Completed by (printed name):_____ Relationship to patient:_____

Signature:_____ Date:_____

Patient Registration
(Newborn- 17-years)

Pediatric Health Care Alliance, P.A.
Your Child's Medical Home™

Name: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Home Address: _____

City: _____ State: _____ Zip: _____

Sibling Names and Ages *(ex: Jack, 9)*: _____

_____

PARENT/GUARDIAN INFORMATION

PRIMARY FAMILY EMAIL: _____

PRIMARY FAMILY PHONE: (_____) _____ *(OFFICE USE: LABEL AS "MAIN")*

Parent Name: _____ Date of Birth: _____

Mobile Phone: (_____) _____ **Work Phone:** (_____) _____

Home Address *(if different from child)*: _____

City: _____ State: _____ Zip: _____

Employer: _____

Parent Name: _____ Date of Birth: _____

Mobile Phone: (_____) _____ **Work Phone:** (_____) _____

Home Address *(if different from child)*: _____

City: _____ State: _____ Zip: _____

Employer: _____

Alternate Contact (relative or friend): _____

Alternate Contact Phone: (_____) _____

Relationship to patient: _____

FORM COMPLETED BY:

Name *(print)*: _____

Signature: _____ **Date:** _____

We are required to collect the following information for each patient.

Please complete this section before returning the form. Thank you.

Preferred Doctor/APRN

_____

Preferred Language:

_____

Your Child's Race
(select one primary)

☐ American Indian or Alaskan Native
☐ Asian
☐ Black/African American
☐ Middle Eastern or North African
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other _____
☐ Decline to answer

Your Child's Ethnicity

☐ Hispanic or Latino
☐ Non-Hispanic or Latino
☐ Unknown

Please confirm your contact information is correct. We use this information to contact you about appointments, alerts, general health information, PHCA news and services, as well as payments and billing matters.

***** Please return this form to the Front Desk before leaving the office. Thank you. *****

Billing Guarantor Acknowledgement (Newborn- 17-years)

Pediatric Health Care Alliance, P.A.
Your Child's Medical Home

Patient Name: _____

Date of Birth: _____

INSURANCE INFORMATION

Insurance Plan Name: _____ Effective Date: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____ Sex: ☐ M ☐ F

Relationship to Patient: ☐ Parent ☐ Legal Guardian ☐ Foster ☐ Parent ☐ Self Other: _____

**** PLEASE NOTE: The insurance policy holder is not automatically the Billing Guarantor. ****
The parent/guardian who is present for office visits is the Billing Guarantor - see below for details.

NOTICE OF FINANCIAL RESPONSIBILITY

I understand that payment for all medical care is due at the time of service. The parent and/or legal guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to Pediatric Health Care Alliance, P.A. to release any pertinent information to my insurance company upon request, and I also authorize payment directly to Pediatric Health Care Alliance, P.A. A photocopy of this authorization shall be considered as effective and valid as the original.

NON-COVERED SERVICES

I am aware that some services performed by Pediatric Health Care Alliance, PA may be considered "non-covered" by my insurance carrier or Medicaid, therefore I will become fully responsible for payment of these services.

DIVORCE/CHILD CUSTODY

Pediatric Health Care Alliance, PA will not honor the specific financial arrangements set forth in a Child Custody Agreement, Divorce Settlement Agreement, Divorce Decree from Judgment, or the like (the "Arrangements"). Since PHCA is not a party to these Arrangements, it is not obligated to the financial terms of these Arrangements.

In cases of child custody, the parent who presents their child (the "Presenting Parent") for care and treatment at PHCA is responsible for the payment of co-pays, co-insurance, and deductibles at the time of service. This policy applies whether there is a joint-custody arrangement of the child and/or joint responsibility for their medical expenses. If the child is on the non-custodial or non-presenting parent's health insurance, then PHCA will still collect the applicable co-pays, coinsurance, and deductibles at the time of service from the Presenting Parent. Upon request, PHCA will provide a duplicate copy of your receipt so that the Presenting Parent or guardian can seek reimbursement where appropriate.

NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how protected health information will be used and disclosed. I understand that Pediatric Health Care Alliance, PA has the right to change its Notice of Privacy Practices that will be effective for health information the practice already has about my child[ren], as well as any they receive in the future. PHCA will post a current copy of the Notice. I understand I may receive a copy of the current Notice upon request.

BILLING GUARANTOR SIGNATURE/CONTACT INFORMATION

☐ **I have read all of the above and understand/agree to all provisions therein regarding financial responsibility, permission for treatment, and Notice of Privacy Practices.**

_____ _____ **Sex:** ☐ **F** ☐ **M**
Billing Guarantor Name *(print)* **Date of Birth** *(mm/dd/yyyy)*

_____ ( ) -
Address / City / State / Zip **Primary Phone**

_____ _____
Billing Guarantor Signature **Today's Date** *(mm/dd/yyyy)*

Relationship to Patient : ☐ Parent ☐ Legal Guardian ☐ Foster Parent ☐ Self ☐ Other: _____

Billing Guidelines

Pediatric Health Care Alliance, P.A.
Your Child's Medical Home™

Patient Name:_____

Date of Birth: _____

Pediatric Health Care Alliance billing policies and a representative list of items with potential fees and charges are outlined below. This information is to ensure you are better informed at the time of service, and prior to the arrival of a billing statement. Please speak with the office manager if you have any questions regarding this information.

- **CO-PAYS:** It is our policy to collect your insurance co-pay at check-in. This simplifies the office process and ensures the financial obligation is met at the time of service.
- **CO-INSURANCE/DEDUCTIBLES:** Every effort is made to fairly estimate the co-insurance or deductible owed based on the nature of the visit. It is our policy to collect these payments at the time of service. We will collect $75.00- weekday visits and $100.00- evening and weekend visits if you have not met your deductible or have a co-insurance due.
- **BILLING:** As a courtesy, Pediatric Health Care Alliance bills your health insurance provider on your behalf, with the following guidelines/exceptions:
  - **Insurance Card: It is critical that the most current insurance card is brought to every appointment.** We must have the correct information at the time of service. An insurance card is similar to a credit card – the information must be current and valid in order for it to be used.
  - **Auto Insurance:** We do not bill auto insurance for visits and medical care related to an auto accident. Payment will be required at the time of service, and we will provide the paperwork needed for you to submit to the auto insurance provider for reimbursement.
  - **Secondary Insurance:** PHCA only bills Tricare and Medicaid from the secondary insurance governmental plans.
- **COMBINED VISITS:** If you are scheduled for a well-child exam, and other health concerns are brought up that would typically require a sick visit, your insurance company may consider these two separate visits and bill your co-pay and other charges accordingly.
- **EVENING/WEEKEND/HOLIDAY SURCHARGE:** Some health insurance providers bill a surcharge of $100.00 if you see your pediatrician after normal business hours, on the weekend, or on a holiday.
- **ADMINISTRATIVE FEES** : PHCA charges various fees for the following items, which require personnel and resources to address.
  - **Copies** of medical records given to the parent (no charge if sent directly to new provider)- $1.00/per page/first 25 pages, then 25¢/per page thereafter.
  - **Miscellaneous forms completion-** school lunch or medication forms - $10.00
  - **Special request completion** of camp or sports physical forms (free during visit)- $20.00
  - **Other forms or letters-** physician letters, college forms, parking permits- $20.00
  - **Completion of** FMLA paperwork or Tricare transfer form- $25.00
  - **Returned check** (for insufficient funds)- $29.00
  - **No-show / late cancellation (15 minutes or greater) fee** when a patient:
    - Sick visit- $25.00- No show or cancellation, less than 2 hours prior to appointment
    - Well Visit- $25.00- No show/same-day cancellation
    - Consultation Visit- $25.00- No show/same-day cancellation
    - EHO visit - $25- No show or cancellation, less than 2 hours prior to appointment
    - Behavioral Health- $50.00 / $100.00 for testing visits

Signature _____ *Date* _____

Consent For Treatment of Minor Child

Pediatric Health Care Alliance, P.A.
Your Child's Medical Home™

MEDICATION AND TREATMENT CONSENT. This Consent Form is intended to confirm written consent for the patient(s) named below (the "Patient") to receive medical treatment at Pediatric Health Care Alliance, P.A. to include services rendered by its employed or contracted providers, and other medical professionals, (collectively "PHCA"). I understand that except as otherwise provided by law, PHCA cannot provide health care services or prescribe medicinal drugs to a minor child without first obtaining written parental or legal guardian consent, as applicable. My signature below hereby confirms my consent for the PHCA and PHCA Providers to provide health care services and prescribe medicinal drugs to the Patient based on the judgment of the PHCA provider, and includes, without limitation, consent for the Patient to be evaluated and treated for medical conditions, including physical or mental health conditions and other sensitive matters, as deemed ordinary and necessary, and advisable, in the judgment of the Patient's PHCA provider.

TREATMENT SERVICES. I understand that medical care and treatment of the Patient that I am consenting to will typically include, as determined by the health care practitioner, ordinary and necessary medical treatment, including a full physical examination including an external genital examination, diagnostic testing, vaccination and the prescribing of medicinal drugs as needed to treat health conditions ("Treatment Services"). By signing below, I acknowledge my consent for the Patient to receive such Treatment Services from PHCA. I acknowledge that this consent specifically expresses my consent for the Patient to receive an external genital exam from a PHCA provider as part of their medical care and treatment. It has been explained to me that I have a choice about the use of Treatment Services at PHCA and other services that may be available or recommended to the Patient during the course of their treatment.

CONSENT TO DISCLOSURE OF HEALTH INFORMATION. To facilitate the treatment services provided by PHCA pursuant to this consent and to coordinate care for the Patient, I hereby authorize and request that copies of prior medical and billing records related to the Patient's treatment services be provided to PHCA. This consent to disclosure specifically includes without limitation, complete psychological and assessment records, most recent plans of treatment, progress summaries, discharge summaries, treatment notes, including mental health information and diagnosis, HIV/AIDS and/or other STD information, substance use, or abuse information, genetic information, and any other appropriately related documents or information reasonably requested by PHCA.

ACKNOWLEDGMENT. By signing below, I represent that I am either a parent or the legal guardian of the minor child/children named below, with the legal right to consent to medical treatment and medication prescribing and administration on behalf of the Patient. I consent to Pediatric Health Care Alliance, P.A. physicians, providers, and other employed or contracted medical professionals to provide, solicit and arrange for health care services, and prescribe medicinal drugs when determined necessary in the professional opinion of the treating PHCA provider, to the Patient(s) named below. Additionally, I have listed other people who are authorized to bring my child/children in for medical care and treatment.

Child/Children:

Print Name of Minor Child: _____ Date of Birth: _____

Print Name of Minor Child: _____ Date of Birth: _____

Print Name of Minor Child: _____ Date of Birth: _____

Print Name of Minor Child: _____ Date of Birth: _____

In my absence I may send any of the following people to accompany my child. They are authorized to consent to any medical care and treatments needed, including examination, vaccination/specimen collection for testing (blood draw, urine collection, throat swab), or medication administration, and to be contacted in case of an emergency:

Name: _____ Phone: ( ) _____ Relationship: _____

Name: _____ Phone: ( ) _____ Relationship: _____

Name: _____ Phone: ( ) _____ Relationship: _____

Name: _____ Phone: ( ) _____ Relationship: _____

Parent/Guardian: This written consent form is valid until it is revoked. If you wish to revoke this written consent, please call your child's home location.

Print Name: _____ Relationship: _____

Signature: _____ Date: _____

For individuals/representatives acting on behalf of the Patient, you must indicate your relationship to the Patient, and provide proof of your authority to act on the patient's behalf (other than natural parents).

Acknowledgement of Pediatric Health Care Alliance Vaccine Policy

Pediatric Health Care Alliance, P.A.
Your Child's Medical Home

Dear Parents,

As part of our commitment to patient-centered care, we are dedicated to protecting the health of our patients and the community through vaccination. Vaccinating children and young adults is one of the most important health-promoting interventions we can perform as healthcare providers, and you can perform as caregivers. Routine childhood immunizations have resulted in a tremendous decline in serious infections, disability, and death. Unfortunately, these illnesses are still present in the United States and other countries and are often just a short plane ride away. We understand that parents have reservations about certain vaccines, and our pediatricians will be happy to discuss those concerns with you as a new patient.

At PHCA our vaccine policy requires that medically able patients need to be fully vaccinated, based on the CDC Recommended Immunization Schedule for Children and Adolescents.

We believe that failure to follow the recommendations about vaccination may endanger the health and life of a child, and others with whom a non-vaccinated child may come into contact. Failure to adhere to this policy will result in dismissal from PHCA. **Therefore, if you have already decided with absolute certainty that you will not vaccinate your child(ren), we encourage you to find another healthcare provider who shares your views.**

NOTE: In accordance with this policy, PHCA requires vaccine records/history prior to the first appointment for any transferring patient.

PHCA Standards for Vaccine Compliance	**Vaccines Needed****			
By the age of 12 mos: Patients must have received these vaccinations recommended for ages 0-9 months	Hep B DTaP	Hib IPV	Pneumococcal	
By the age of 24 mos: Patient must have received these vaccinations recommended by 18 months of age	Hep B DTaP	Hib IPV	Pneumococcal MMR	Varicella
By the age of 5 yrs & 11 mos: patient must have received these vaccinations recommended by 6 years of age	Hep B DTaP	Hib IPV	Pneumococcal MMR	Varicella
By the age of 12 yrs & 11 mos: patient must have received these vaccinations recommended by 13 years of age	All of the above, plus Tdap			

***Please note: While PHCA strongly recommends all childhood vaccines, we are allowing limited exceptions to the vaccine compliance policy. Rotavirus, Hep A, Influenza, Meningococcal, COVID, and HPV vaccines are recommended but not required as part of our policy.*

The decision to adopt a more stringent policy regarding vaccination stems from the risk that a non-vaccinated child poses to other patients in our office, and vulnerable families such as newborns or children with weakened immune systems. As a pediatric group, we feel a powerful responsibility to work towards protecting our community from illness as much as possible.

Please note, that if you feel your child has a health condition that does not allow vaccination, please Let us know.

Patient Name:_____

Date of Birth: _____

Parent/Patient Signature:_____ **Date:**_____

Shared Custody Statement

Pediatric Health Care Alliance, P.A.
Your Child's Medical Home™

Pediatric Health Care Alliance, P.A. ("PHCA") is dedicated to the health and well-being of our patients. Because our patients are children, we rely on parents, legal guardians, and other supportive adults to assist us in their care. Given the sensitive nature of the unique challenges that can arise when children of divorced or separated parents need medical care, we want to share PHCA's philosophy with you to help navigate these sensitive areas and avoid misunderstandings during the treatment process.

In general, we ask that parents NOT place our office in the middle of family disagreements. We do not believe this is the best interest of patients and rely on parents to keep our practice atmosphere calm, professional and caring for the children we serve.

1. State and federal privacy laws provide that both parents, custodial or non-custodial, have a right to the child's medical record and information about their care unless a court has determined otherwise. If either parent requests information, we will honor that request. If a Court Order has been issued that restricts either parent's role, please provide a copy of the Court Order to our office.

2. Step-parents are not generally authorized under the law to consent to medical treatment for a child. If a step-parent will be bringing the child in, they must be listed on the permission to treat form to be seen. Please assist us by keeping your paperwork current.

3. We may communicate about a patient's care with one parent, based on who is involved in the patient encounter. We rely on parents to communicate with each other about the child's visit, dates of appointments, treatment recommendations, and other relevant issues, rather than calling both parents separately to discuss the visit due to lack of communication between parents.

4. The parent who brings the child in for an appointment is responsible for co-pays or insurance deductible payments at the time of service, even if the other parent is responsible for medical insurance. Please do not ask our office to collect payments from a parent who is not at or may be unaware of the visit.

5. Both parents are attending the appointment- in a non-urgent situation, if parents disagree about medical treatment (e.g., to vaccinate or not vaccinate) we will postpone recommended treatment until there is an agreement between both parents.

6. If there is an urgent situation and the child is extremely ill, we will do what we feel is in the best interest of the child in a manner provided for under applicable law.

7. Other situations that are not in the best interest of your child and will not be tolerated and may lead to dismissal from PHCA:

a. One parent makes appointments, and the other one cancels them.
b. A parent who asks us to write or say negative things about the other parent.
c. Parents who fight or create conflict in our offices.
d. Any other behaviors which interfere with our ability to provide excellent medical care to all of our patients in a warm and peaceful environment.
e. Changing demographics, email address or portal username/password without notifying the other parent.

We sincerely appreciate your trust in us, and ours in you, to work together in the best interest of children's health.

PEDIATRIC HEALTH CARE ALLIANCE, P.A.
Your Child's Medical Home

Electronic Transmission of Private Health Information (PHI)

Pediatric Health Care Alliance (PHCA) is committed to ensuring the privacy and security of your protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act (HIPAA). As part of our commitment to safeguarding your PHI, we have implemented secure methods for transmitting medical records.

HIPAA Compliant Encrypted Email: PHCA utilizes HIPAA-compliant encrypted email services to securely transmit medical records containing PHI. This ensures that your sensitive information remains confidential during electronic transmission.

HIPAA Compliant Encrypted Email and Fax Transmission: PHCA utilizes HIPAA-compliant encrypted email services to securely transmit medical records containing PHI. This ensures that your sensitive information remains confidential during electronic transmission. In addition to encrypted email, PHCA may also transmit medical records via fax using secure fax machines. This method complies with HIPAA guidelines for safeguarding PHI during transmission.

Use of Artificial Intelligence (AI) in Healthcare: This practice may utilize artificial intelligence (AI) tools to assist with tasks such as documenting patient encounters, analyzing medical images, and identifying potential health risks. These AI tools are designed to assist healthcare providers, not replace them. All AI-generated information will be reviewed and verified by a qualified healthcare provider. Your privacy and the security of your health information will be protected in accordance with HIPAA regulations. By signing this form, you acknowledge and authorize the use of AI tools in your healthcare.
I grant permission for PHCA to record my child's health information using A.I. generated dictation to the EMR system. I understand that all transcriptions will be handled in accordance with HIPAA regulations to ensure privacy and confidentiality. *By employing these secure methods, Pediatric Health Care Alliance aims to protect the confidentiality, integrity, and availability of your medical records. If you have any questions or concerns regarding the transmission of your PHI, please contact our Privacy Officer at 813.262.9341.*

Digital Updates and Communication: I acknowledge that PHCA may contact me for various purposes through email or text messaging, including but not limited to updates, reminders, and other relevant communications.

Purpose of Transmission: I understand that my health information will be transmitted electronically for the purpose of facilitating medical care, treatment, and related administrative functions.

Types of Information: I acknowledge that the information transmitted may include sensitive and confidential details about my health condition, medical history, medications, and other relevant data necessary for healthcare provision.

Security Measures/Potential Risks: I understand that PHCA will take appropriate security measures to safeguard my health information during transmission. However, I acknowledge that no electronic transmission can be guaranteed to be 100% secure. I am aware of the potential risks associated with electronic transmission, including but not limited to interception by unauthorized parties, data breaches, and loss of confidentiality.

Revocation/Duration of Consent: I understand that I have the right to revoke this consent at any time by providing written notice to PHCA. However, I acknowledge that revocation will not apply to actions already taken in reliance on this consent. This consent shall remain valid until revoked by me in writing or until the completion of the purposes for which it was provided, whichever comes first.

Signature: By signing this form, I affirm that I have read and understood the contents of this consent form, and I voluntarily authorize the electronic transmission of my private health information as described herein.

Parent Signature: _____ Date: _____
Parent Name (please print): _____
Child(ren) Name/DOB: _____
_____

PEDIATRIC HEALTH CARE ALLIANCE, P.A.
Your Child's Medical Home™

☐ Apollo Beach Office	225 Harbor Village Lane	Apollo Beach, FL 33572	(813) 493-1779
☐ Big Bend Office	10729 Queens Town Dr	Riverview, FL 33579	(813) 672-3497
☐ Brandon Community Office	811 S Parsons Ave	Brandon, FL 33511	(813) 685-4553
☐ Citrus Park Office	6550 Gunn Hwy	Tampa, FL 33625	(813) 968-2710
☐ Crossroads Office	6671 13th Avenue N #1D	St. Petersburg, FL 33710	(727) 381-1147
☐ FishHawk Office	5621 Skytop Dr	Lithia, FL 33547	(813) 571-6800
☐ Lutz Office	1854 Oak Grove Blvd.	Lutz, FL 33559	(813) 948-6133
☐ North Carrollwood Office	3638 Madaca Lane	Tampa, FL 33618	(813) 968-6610
☐ Northside Office	4446 E Fletcher Ave Ste A	Tampa, FL 33613	(813) 971-6700
☐ South Tampa Office	3222 W Azeele St	Tampa, FL 33609	(813) 872-8491
☐ South Manhattan	4911 S. Manhattan Ave.	Tampa, FL 33611	(813) 755-4025
☐ Odessa (Suncoast) Office	14713 Sully Run	Odessa, FL 33556	(813) 475-7100
☐ Walsingham Office	12951 Walsingham Rd	Largo, FL 33774	(727) 391-0158
☐ Wesley Chapel Office	5259 Village Market	Wesley Chapel, FL 33544	(813) 973-0333
☐ Wiregrass Office	27432 Cashford Cir Ste 102	Wesley Chapel, FL 33544	(813) 973-9982

Release of Medical Records TO Pediatric Health Care Alliance

***** Immediate: Please fax immunization records only to (_____) _____ - _____ *****

Please mail full records to the office location and address checked above.

Notes: _____

_____

Patient Information

Patient Name:_____ DOB:__/__/____

Patient Name:_____ DOB:__/__/____

Patient Name:_____ DOB:__/__/____

Patient Name:_____ DOB:__/__/____

Patient Name:_____ DOB:__/__/____

Release Records FROM *(doctor or facility name)*: _____

Address:_____

City / State / Zip:_____ Phone: (___) _____ - _____ Fax: (___) _____ - _____

Authorization *(initial each item below)*

___ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

___ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

___ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

___ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

This authorization will expire on (insert date or event): _____

If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

Name (print) **Signature** **Date**

Relationship to Patient: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Other (please specify): _____

Witness Name (print) **Witness Signature** **Date**