Marin Pediatric Associates, Inc., a UCSF affiliated practice

Jane M. Meill, M.D.
Kara S. Ornstein, M.D
Nancy L. Schwartzman, M.D.
Amy Stenback, M.D.
Shelley A. Palfy, M.D.
Diplomates, American Board of Pediatrics

1100 South Eliseo Dr. Ste 106
Greenbrae, CA 94904
(415) 461-8828
Fax (415) 461-3772
www.marinpediatricassociates.com

AUTHORIZATION TO EXCHANGE MEDICAL INFORMATION 7/18

Please provide all information requested or this authorization is not valid. Please print.

FOR OUR PATIENTS 18 YEARS OF AGE AND OLDER:

HIPPA regulations prohibit us from discussing any of your medical information with your parents or guardians without your express permission. So please list the names of people with whom we may discuss your medical care and what if any limitations apply (see list below). We are also required to provide you with information about Advanced Directive for Medical Care.

I hereby authorize Marin Pediatric Associates to provide medical information to:

Name: (e.g: parent)	Phone: ( )
Name: (e.g: parent)	Phone: ( )
Name:	Phone: ( )

Records pertaining to:

Patient's Name:_____**DOB:**_____

Data Requested: Please CIRCLE Yes or No and ***initial*** appropriate choices.

Yes	No	_____(initial)	Portions of Medical record necessary for ongoing care, including shot records, X-ray reports, lab reports, consultations
Yes	No	_____(initial)	Mental Health information
Yes	No	_____(initial)	Drug/Alcohol information
Yes	No	_____(initial)	HIV test results
Yes	No	_____(initial)	Genetic records
Yes	No	_____(initial)	Developmental/Learning disorders
Yes	No	_____(initial)	Sexual Health
Yes	No	_____(initial)	Other (Specify):_____

For the **Purpose** of: ❑ ongoing healthcare ❑ other:_____

Permission to fax and/or send electronically: ❑ Yes ❑ No

All faxed material will contain a confidentiality statement: however, I understand confidentiality at the receiving end cannot always be assured.

Duration: This authorization is effective indefinitely from the date of signature, or until revoked by patient.

Revocation: This authorization may be revoked at any time, except to the extent that action has been taken on this authorization.

Redisclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Advanced Directive: ❑ Yes, I have received information about Advanced Directives.

✎_____ _____

Signature: Patient date

Marin Pediatric Associates, Inc., a UCSF affiliated practice

Patient Information

DEMOGRAPHIC INFORMATION –CHANGES Date:

*Cell # required for teens

Patient #1 Full Name (first middle last)	Gender M / F	Date of Birth	*Cell #
Patient #2 Full Name	Gender M / F	Date of Birth	*Cell #
Patient #3 Full Name	Gender M / F	Date of Birth	*Cell #
Patient #4 Full Name	Gender M / F	Date of Birth	*Cell #

Address: Street	Telephone:
City Zip	primary language(s) spoken
Mailing Address (if different)	

Parent/Guardian Information

Parent #1 Full Name	Gender M / F	Date of Birth	Social Security Number
Address: Street (if different)		Telephone	
City Zip		Cell phone	
Employer/Occupation		Work phone	
other contact info: Fax:	E-mail:		
Parent #2 Full Name	Gender M / F	Date of Birth	Social Security Number
Address: Street (if different)		Telephone	
City Zip		Cell phone	
Employer/Occupation		Work phone	
other contact info: Fax:	E-mail:		

Step Parent(s):

Adults (other than parents) authorized to seek medical care for patient(s):

Primary Care Physician (please circle one)

Jane Meill, M.D. **Kara Ornstein, M.D.** **Nancy Schwartzman, M.D.** **Amy Stenback, M.D.** **Shelley Palfy, M.D.**

Consent for Treatment: By signing below, I authorize provision of medical care for myself (>18yr) or the above named minor patient(s) by the physicians of MPA, or their designates.

✎

relationship to patient(s): Date:

Additional helpful information:

Preferred Pharmacy:

Marin Pediatric Associates, Inc., a UCSF affiliated practice

UPDATES or CHANGES: Financial/Billing Information: 7/18

For patients aged 18+, adding new family member, or changes to existing patients

CHANGES: Date information provided:_____

Patient Name(s):_____

Who is financially responsible for payment of services provided by Marin Pediatric Associates?*

Name: _____ relationship to patient(s) _____ Social Security Number: _____

Address(if different): _____ Telephone: _____

✎_____ Date: _____

By my signature above, I authorize release of required information, direct payment of benefits to MPA, **AND** I acknowledge my financial responsibility for all charges incurred at MPA.

***IF YOU ARE NOW 18 OR OLDER, PLEASE HAVE YOUR PARENT/GUARDIAN SIGN ABOVE IF THEY WILL CONTINUE TO BE RESPONSIBLE FOR BILLS.**

Please read the MPA Financial Policy that follows for a detailed listing of our policies and fees.

OLD Insurance Company: _____ End (Termination) Date of Coverage: _____

CURRENT or NEW Insurance Information:

While we are happy to file insurance claims for our patients and assist them in resolving any disputes with their insurance companies regarding benefits, parents/guardians remain responsible for payment for services provided by MPA regardless of insurance.

If you would like us to file claims with your insurance on your behalf, ***we require ALL of the following information:***
A ***current, VERIFIABLE copy*** of your insurance card must be on file with every visit. (a $25 re-filing fee applies to any claim if information is not brought up to date at the time of the visit)

Name of the main policy holder (i.e: the subscriber or employee): Subscriber's Date of Birth:

_____

Address (if different) Subscriber's Social Security Number

_____

Insurance Company Copay (if any) Effective Date of Coverage:

_____

Scanned to EPIC by: _____ Date: _____