CONSENT TO TREAT A MINOR &
USE, DISCLOSURE & RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Note: ***This consent expires on December 31st of each year but may be revoked at any time by written request. A new consent must be submitted annually.***

Name of Patient: _____ Date of Birth: MM/DD/YYYY _____

A. CONSENT FOR TREATMENT

I, as the Parent/Legal Guardian hereby give my consent for the above-named minor to be examined and/or treated by Shalom Health Care Center's ("Shalom") medical and behavioral health clinicians for primary care, behavioral health, and telehealth services. I understand and agree that any in-depth examination and/or procedures will be explained to me before giving my consent.

I have been given the option to receive copies of Shalom's **"**Notice of Privacy Practices" prior to signing this Patient Consent and understand that it provides a more complete description of such uses and disclosures. Shalom reserves the right to revise its "Notice of Privacy Practices" at any time. Such revisions will be made available to me by copy or accessible electronically on Shalom's website and Patient Portal.

B. DATA / HEALTH INFORMATION EXCHANGE CONSENT

Shalom participates in a data exchange network, Healow Insights, within our electronic medical record (EMR), eClinicalWorks (eCW), to improve the continuum of care and quality of services. This means eCW will send clinical documents when requested by external connected sites and will also request clinical documents from external connected sites and display them in eCW. We share your health information with your other medical facilities, your selected pharmacies and other healthcare entities for the exclusive use of your treatment.

If you would like to change your data exchange consent, please provide written notice prior to sharing my health information to: Opt In: Send Documents only, Opt In: Receive Documents only, or Opt Out.
Please note that opting out may delay your health services and continuity of care.

C. PATIENT COMMUNICATION

With this consent, I am authorizing Shalom and its representatives to communicate with me using the following methods:

- Call or text my home or alternative contact number and leave a message on voice mail or in-person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. I understand that standard text messaging rates may apply to me at my cost.

- Correspond with me via regular postal mail or electronic mail to my home or other alternative location on any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.

FOR OFFICE USE ONLY: ACCOUNT #: _____

PLEASE CONTINUE TO OTHER SIDE

D. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I have the right to request that Shalom restrict how it uses or discloses my 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 Patient Consent.

I am consenting to Shalom Health Care Center, Inc.'s use and disclosure of my PHI to carry out TPO. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My revocation must be submitted in writing to:

HIPAA Compliance Officer
Shalom Health Care Center, Inc.
3400 Lafayette Road, Suite 200
Indianapolis, IN 46222-1147

E. AUTHORIZATION

I, as the Parent/Legal Guardian of the above-named minor, do hereby authorize the designated individual(s) listed below (must be 18 years of age or older) to consent to treatment at future visits for the above-named minor when I am unavailable. I have the right to revoke this approval at any time by communicating this decision in writing. Any person not included on this list will not be authorized to consent treatment.

Stepparents must be listed below in order for the Provider to provide treatment. If you are the mother or father signing this authorization, please list the other parent's name below.

☐ NO CHANGE TO THOSE CURRENTLY AUTHORIZED ON FILE

Print Full Name of Individual Authorized to Consent	Relationship to Patient	Phone Number
1.		
2.		
3.		

F. RELEASE OF INFORMATION

I further authorize the above-named individual(s) to act on my behalf in the following areas:
(Please circle the number that corresponds to the above listed individuals in section E).

1	2	3	Schedule appointments for my child
1	2	3	Bring my child to their appointment(s)
1	2	3	Receive messages containing protected health information (PHI)
1	2	3	To pick up prescriptions for my child (excludes controlled substances)
1	2	3	To request and receive PHI/medical records for my child
1	2	3	I authorize all listed individuals to do **all the above**

☐ I decline authorization to share protected health information. This information should only be released to me.

G. ACKNOWLEDGEMENT

This authorization will expire on December 31st of each year, when the above stated minor reaches the age of 18 or ceases to be a patient (whichever comes first). I understand that I may revoke this authorization at any time by submitting my request in writing to: Shalom Health Care Center, 3400 Lafayette Road, Suite 200, Indianapolis, IN 46222. The revocation will be effective 2 business days after receipt by the HIPAA Compliance Officer or their Designee. I understand that I am under no obligation to sign this authorization as a condition of treatment. I understand that upon release and disclosure of the protected medical records and information, it may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations. Adults (18 years or older) authorized to receive protected health information must present proper identification on all requests for PHI.

Parent/Guardian Name: _____ Relationship to Patient: _____

Parent/Guardian Signature: _____ Date: MM/DD/YYYY _____

HIPPA AUTHORIZATION COMPLETED IN ECW – STAFF INITIALS: _____