**Priority Care Pediatrics, LLC**
**6320 N Lucerne Ave**
**Kansas City, Missouri 64151**
**(816) 412-2900**

# Patient Universal Authorization Form

In this document, "we," "us," and "our" refer to the parent(s), guardian(s), and/or patient, and "office" means Priority Care Pediatrics, LLC, its providers, staff members, and authorized agents. With the signature below, we grant the following permissions to the office. This permission shall remain in effect until our termination from the practice (either by our action or that of the office) or until revoked in writing by either party. Such revocation of permission shall not apply to any uses which occurred prior to the revocation. We understand that certain permissions may be allowed and others declined; in this case, a separate document must be created; this form shall be used only when all permissions are allowed. We understand that we may change these permissions at any time.

**Permission to submit insurance:** We grant the office and its billing service(s) permission to submit our insurance claim to the proper insurance company, whether we disclose the insurance or if it is discovered through other means. This includes transmission of the federally mandated information required for billing including the date of service, name, date of birth, address, social security number of the patient and insured, procedures or services performed, and the appropriate diagnosis(es), as well as any other necessary information. Further, invoices mailed to any address on file with our office are permitted with the same permitted information contained therein.

**Permission to contact us:** We grant the office permission to contact us by mail, phone, fax, text message, and email using the contact information we have provided for that purpose or that information which is discovered through other sources (such as insurance companies, hospital records, emergency contacts, etc.). During the course of your child's care, it will be necessary for our staff and providers to communicate about him/her. You give consent for our internal staff and providers to share the child's health information between themselves and with any necessary specialists. The means of which we may share this information will be by external sources, through verbal, text, and written means. If we provide an email address, we agree to keep this email address updated and to check it regularly. Other contact methods are also permitted if we provide them for use by the office. This contact shall ONLY occur within the appropriate privacy guidelines as required by law and as addressed in the Privacy Practices which we have reviewed and signed. We understand that the office may use a live or automated service to notify us of an upcoming appointment, but the lack of such notification does not release us from a responsibility to keep or cancel the appointment as required by the office's guidelines and/or policies.

**Permission for patient picture(s):** If we allow a digital picture of the patient to be taken in the office, we grant permission for the office to store the picture in the patient's

electronic medical record for office use only. We understand that this picture will never be distributed in any other format or used in any other way without our express permission. Such pictures may be transferred as a part of a medical records transfer in accordance with a records transfer request and/or as otherwise allowed by the office's Privacy Practices. If we provide a picture to the office (f.ex. holiday card or school picture), we understand that it may be displayed in the office in live or electronic format in perpetuity similar to pictures already displayed in the office. Pictures drawn by a patient and provided to the office (in live or electronic format) may be displayed by the office in live or electronic format in perpetuity. If any picture or drawing provided to the office has a name or other identifying information already printed or otherwise displayed upon it, this may be displayed even if it otherwise constitutes personal health information.

_____ _____
Signature of Parent or Guardian Date

_____
Printed Name of Parent or Guardian

_____ _____
Printed Name of Patient Signature of Patient if ≥ 7 yrs old and capable of signing

Written January, 2004
Revised October, 2012
Revised November, 2017