3721 Lynn Road, Suite 104  Raleigh, NC 27613  Office: 919 825-3600  Fax: 984 200-6001

# Authorization to Use/Release/Disclose Health Information

Please complete one form per child

Please Note:  We can serve your child better if we receive your child's previous Medical Records prior to your first scheduled appointment.  Established patients of Dr. Mack may schedule visits before their records arrive at Mack Pediatrics.

I hereby authorize the use, release and/or disclosure of my health information as described below.

Patient Name:_____ Date of Birth:____/____/_____

| Organization Providing the Information: | Organization Receiving the Information: |
|---|---|
| Oberlin Road Pediatrics<br>1321 Oberlin Road, Suite A<br>Raleigh, NC 27608<br>Phone 919-828-4747  Fax 919-828-6765 | Mack Pediatrics<br>3721 Lynn Road, Suite 104<br>Raleigh, NC 27613<br>Phone 919-825-3600  Fax 984-200-6001 |

I authorize this information to be sent to Mack Pediatrics at the above address:
X  Customized records transfer per Dr. Mack and Penny at Oberlin

- I have the right to revoke this Authorization, in writing, at any time by notifying Mack Pediatrics. Such revocation will not apply to information that has already been disclosed in reliance of this Authorization.
- I have the right not to sign this Authorization. Mack Pediatrics will not condition treatments, payment for services or enrollment or eligibility for benefit on whether I sign this Authorization.
- The Organization Providing the Information may deny in writing your request to inspect and/or copy your PHI in limited circumstances. You may request a review of the denial in writing. Another licensed health care professional, chosen by them, will conduct a review of the denial.
- I have read and understand this Authorization, have had the opportunity to have my questions answered, have signed this Authorization freely and have received a copy of this Authorization.
- This Authorization expires one year after the date below unless otherwise specified:_____

Signature: _____Name:_____ Date ____/____/_____
Relationship to Child:_____

MACK PEDIATRICS

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# Acknowledgment of Receipt - Notice of Privacy Practices

Please complete one form per child

I have received a copy of the HIPAA roles and regulations to review for my knowledge and use. I have the right to request a copy for my own use.

Patient: _____ Date of Birth:____/____/_____
Person signing for patient: _____
Signature: _____
Relationship to patient: _____

If Patient or Patient's personal representative does not sign, indicate below the reasons why signature could not be obtained:

_____

Name of practice staff member:_____Date:____/____/_____

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# Patient Medical/Social History (please complete one per child)

Name of patient (child): _____
Date of Birth:____/____/_____ Today's Date:____/____/_____
If applicable, patient's cell phone number: _____

Is your child allergic to any medication? No__ Yes___ If yes, please indicate the name of medication(s) and type of reaction:_____
Has your child had a serious reaction to an immunization? No__ Yes___ If yes, which immunization and type of reaction? _____
Does your child have any food allergies? No__ Yes___ If yes, please list food/reaction:_____
_____
Has your child been prescribed an epinephrine injector (Epi-Pen or Auvi-Q) for a severe allergic reaction? No__ Yes___

Medications your child is taking (include herbals and vitamins):

| MEDICATION | DOSAGE | TIMES A DAY |
|---|---|---|
| | | |
| | | |
| | | |

Check yes if your child currently has or has had any of the following medical conditions:

| | yes | | yes |
|---|---|---|---|
| Attention Deficit Disorder | | Hearing problems | |
| Asthma | | Vision problems | |
| Frequent wheezing or coughing | | Teeth problems | |
| Urinary tract infections | | Constipation | |
| Recurrent or frequent ear infections | | Anemia | |
| Recurrent or frequent strep throat | | Eczema, hives or skin conditions | |
| Heart murmur | | Convulsions/ central nervous system problems | |

Other medical conditions not listed above?_____
Any hospitalizations? Please describe (date/ location/ reason):_____
Any surgeries? No__ Yes___ If yes, please complete indented list below:
Ear tube placement? No__ Yes___ If yes, at what age?_____
Tonsillectomy? No__ Yes___ If yes, at what age?_____
Adenoidectomy? No__ Yes___ If yes, at what age?_____
Other surgeries, including circumcision?_____
Any serious injuries? No__ Yes___ If yes, what and at what age?_____
Prematurity or complications at birth? No__ Yes___ Please describe_____

Has anyone in your child's immediate family had any of the following conditions?

| | Yes | Relationship to child | | Yes | Relationship to child |
|---|---|---|---|---|---|
| High blood pressure | | | Sickle cell anemia | | |
| Heart attack age <55 | | | Cystic fibrosis | | |
| Stroke at age <55 | | | Hemophilia | | |
| Diabetes Type 1 | | | Tuberculosis | | |
| Diabetes Type 2 | | | Hepatitis | | |
| High cholesterol | | | AIDS | | |
| Thyroid problems | | | Mental illness | | |
| Obesity | | | SIDS | | |
| Asthma | | | Cancer | | |
| Allergic disorders | | | Genetic syndromes | | |
| Seizures/epilepsy | | | Deafness | | |
| Migraine headaches | | | Drug or alcohol abuse | | |

Social History/Safety/Environment:

| | | | |
|---|---|---|---|
| What type of home do you live in? | House | Apartment | Other:_____ |
| What is the source of your child's drinking water? | City | Public well | Private well \| Bottled |
| Is there a working smoke detector on every floor at home? | No | Yes | |
| Does anyone smoke in the home? | No | Yes | |
| Is there any violence in the home? | No | Yes | |
| Is your child in daycare or preschool? | No | Yes | Where? |
| Is your child enrolled in school? | No | Yes | Where? |
| If your child is less than 6 years old, do they use a carseat? | No | Yes | |
| If your child is 4-12 years old, do they use a booster seat in the car? | No | Yes | |
| If your child is less than 13 years old, do they ride in the back-seat of the car? | No | Yes | |
| Does your child wear a seat belt when in a car? | No | Yes | |
| Does your child wear a helmet when riding a bicycle or using a scooter? | No | Yes | |
| Do you have pets? | No | Yes | If yes, what kind? _____ |
| Are there guns or firearms in your home? | No | Yes | If yes, how are they secured? _____ |

If transferring here from elsewhere, does your child have a record of vaccinations? No__ Yes___
Is your child adopted? No__ Yes___ If yes, from what country or geographic area? _____
At what age was your child when adopted?:_____

Signature: _____Name:_____ Date ____/____/_____
Relationship to child:_____
_____

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# Vaccination Policy (please complete one per child)

The physicians and staff of Mack Pediatrics fully support the efficacy and safety of vaccines (aka shots, immunizations, vaccinations). We follow the standard vaccination schedule as recommended by the ACIP (Advisory Committee on Immunization Practice, part of the CDC Centers for Disease Control and Prevention) and the North Carolina State Law as the minimum requirement for vaccination for all of our patients. Mack Pediatrics expects our patients to be vaccinated on time per the ACIP schedule, starting with the Hepatitis B vaccine in the first 24 hours of life in the hospital or birthing center (if vaccine is available).

If you are transferring your child into our practice from another medical provider, we will review the child's immunization records. If we determine that your child is significantly delayed or behind on shots, you will be asked to schedule a vaccine consultation before we will see your child as a patient. We will work with new families to comply with vaccine recommendations and get back on track for your child's current age. However, if a requested vaccine consultation does not occur, or if you are not willing to comply with NC vaccination laws, Mack Pediatrics is not the right practice for your family and we will not accept the child as a new patient. If you decide during the course of being a patient family here at Mack Pediatrics that you do not wish to continue to comply with the NC vaccination laws, then you acknowledge here that your children will be dismissed from Mack Pediatrics and will need another pediatric practice.

We are happy to discuss your questions about vaccines during wellness appointments. If there are extensive concerns or questions, parents will need to set up a separate vaccine consultation appointment. It is important to understand that this visit may not be covered by insurance and parents will be responsible for paying for this consultation at the time of service. Such consultations usually range in cost from $150-$300, depending on the amount of time spent with the physician.

Vaccine Consent Form:

By signing this consent, I am giving Mack Pediatrics permission to vaccinate my child at this and future appointments. I will be offered a Vaccine Information Statement explaining each vaccine before it is administered. I may also refer to https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html for the Immunization Schedules of the Centers for Disease Control and Prevention.

I, parent/guardian of _____ (child's name) have read the vaccination policy and give permission for age-appropriate immunizations to be administered.

Signature: _____Name:_____ Date ____/____/_____

Relationship to child:_____