

Patient HIPAA, RX History and MIIS



I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g., my insurance company)
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

Massachusetts law (M.G.L. c. 111, Section 24M) requires providers to report immunization information to a computerized immunization registry known as the Massachusetts Immunization Information System (MIIS). The MIIS stores immunization records for you and your healthcare provider and can help prevent outbreaks of disease like measles and the flu. All information in the MIIS is kept secure and confidential. The MIIS allows information to be shared with health care providers, school nurses, local boards of health, and state agencies concerned with immunization.

You have the right to object to the sharing of your immunization information across providers in the MIIS. For more information, please ask your healthcare provider visit the MIIS website at mass.gov/dph/miis or contact the Massachusetts Immunization Program directly at **617-983-6800** or **888-658-2850**.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with the restriction.

I authorize Bridgewater Pediatrics, LLC, and its Affiliated Providers to view my external prescription history via the RxHub Service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here.

I authorize Bridgewater Pediatrics, LLC, and its Affiliated Providers to leave voice messages on my cell phone, land line, or other phone number that I have provided.

I authorize Bridgewater Pediatrics, LLC, and its Affiliated Providers to discuss any health issue with the people listed below:

Name: _____

Relationship: _____

Phone: _____

Name: _____

Relationship: _____

Phone: _____

Name: _____

Relationship: _____

Phone: _____

Name: _____

Relationship: _____

Phone: _____

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date: _____

Patient name: _____

Signature: _____

Relationship to patient: _____