WELCOME TO PEDIATRICS 2000 II PC

_____ _____
Patient's Last, First, Middle Name **Preferred Provider**

_____ _____
Address, Apt # **DOB**

_____ _____
City, State, Zip Code **Sex**

_____ _____ _____
Home # **Cell #** **Work #, Ext**

_____ _____ _____
Mother's Name **DOB** **Marital Status**

_____ _____ _____
Father's Name **DOB** **Marital Status**

_____ _____ _____
Emergency Contact Name **Telephone #** **Relationship**

_____
Legal Guardian's name only if different from parents

_____
E-Mail address (if available)

_____ _____
Parent's Nationality **Race/Ethnicity (Voluntary)**

_____
Preferred Pharmacy Name and/or address/phone # if known

_____
Language Preference

_____
How did you find out about our clinic?

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

☹☺ Medical Record from (insert date)_____ to (insert date) _____

☹☺ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☹☺ Other:_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☹☺ By initialing here_____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☹☺ At request of individual ☹☺ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Pediatrics 2000 Vaccine Policy Statement

For the past many years our doctors and nurse practitioners have done our best to support families who are concerned about vaccinating their children. Our philosophy has been that it is our role to provide reasoned, scientific information that can help alleviate those concerns and ultimately encourage all parents to comply with the recommendations of the medical community. Unfortunately, there is a small group of parents that insist that they will not vaccinate their children, or that they have found a schedule of vaccination that they feel is safer than the schedule recommended by health care experts worldwide. Groups in our society that use the Internet to spread a variety of untruths have promoted this phenomenon. Numerous worldwide scientific studies have confirmed the safety of vaccines and evidence based medicine. Recent events have caused us to re-evaluate our policy regarding unvaccinated or under-vaccinated children using our practice for health care. Around the country, the actions of relatively few parents have put many of the most vulnerable at risk. Whooping cough and measles are now in full resurgence. These diseases are life threatening, especially to our youngest patients. Infants and those undergoing chemotherapy may be unprotected against these diseases. Additionally, children exposed to diseases such as measles require weeks of quarantine creating a tremendous burden to working parents. In the face of recent outbreaks, **we no longer have the option of supporting families who choose not to vaccinate or to delay recommended vaccines. Many of our vaccine-compliant patients have voiced concern about possible exposure in our health care facilities. It is our duty to provide the safest environment possible to receive health care.**

At Pediatrics 2000:

- We firmly believe in the effectiveness of evidence based medicine and the administration of vaccines which prevent serious illness and save lives.
- We firmly believe in the safety of our vaccines.
- We firmly believe that all children should receive all of the recommended vaccines according to the schedule published by the Advisory Committee on Immunization Practices (ACIP) of the U.S. Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP).
- We firmly believe, based on all available literature, evidence, and current studies, that vaccines do not cause autism or other developmental disabilities.

All of our providers believe that vaccinating your children may be the single most important health-promoting and life-saving intervention that you can perform as parents. Public health policy exists to promote the well being of all the children in our community.

Effective as of March 1, 2017 our practice will not accept new families that do not believe in vaccination of their children. Established patients of Pediatrics 2000 that are behind on the State of New York required vaccines will be given sufficient notice and time to bring their children up to date. Patients that are behind on the required vaccines will be given up to __6__ ( ) months to come into compliance with our new policy. If your child is behind we will provide easy access to getting your child up to date.

As a result of the foregoing, Pediatrics 2000 hereby sets forth our policy on evidence based medicine. Our policy states:

1. All children must receive all vaccines recommended by the AAP that are mandated for school entry by the State of New York, as well as the complete Hib and Prevnar series.

2. All children must begin receiving their immunizations at age 2 months and be up-to-date on all required vaccines (including MMR and Varicella) by the age of 2 years.

3. We will utilize the immunization schedule as determined by the AAP and CDC.

4. If a parent or caregiver elects to limit their child to 2 vaccines at a time, they must come into the office at 2-4 week intervals to stay within the recommended "window" for the vaccines.

5. If a parent or caregiver elects to limit their child to 1 vaccine at a time, they must come into the office at weekly intervals to stay within the recommended "window" for the vaccines.

6. All parents who don't follow the AAP vaccine guidelines must sign a waiver that they are utilizing an alternate vaccine schedule. This schedule must be approved by a physician or nurse practitioner.

7. Exceptions for the AAP window include: Hepatitis B, Hepatitis A, Influenza, and HPV.

8. The Hepatitis B series must be completed by the time of school entry.

9. The Hepatitis A series, although strongly recommended by our providers, may be deferred until such time that New York State requires it for school entry.

10. The Influenza vaccine is strongly recommended yearly for all children over the age of 6 months, however it is not mandatory at this time.

11. The Gardasil (Human Papilloma Virus) vaccine series is approved and strongly recommended for older children and teens, ideally between the ages of 11-13, but it is not mandatory at this time.

12. Parents or caregivers who don't agree with the Pediatrics 2000 vaccine policy will be given a _30__ ( ) days grace period to find another Pediatric practice. We will offer as much help as we can in helping you select a new pediatric provider who will accept families who choose not to vaccinate their children. Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and disability, even death.

CDC guidelines provide a window for when a specific vaccine should be given. This allows sufficient flexibility in getting your child properly vaccinated. We prefer to remain your child's Pediatrician and will not dismiss any family who is actively working to properly vaccinate their children. Our staff of doctors and nurses is here to help. Please contact us if you have any questions or concerns.

Patient Name: _____

Parents Signature: _____

Date: _____