Karin Varblow, MD, PC
1319 Vincent Place
McLean, Virginia 22101
703-996-4737
www.drkarinmd.com

Confidentiality for Young Adult Patients

As an individual who is over 18 years of age, you have the legal right to privacy with regards to your medical treatment, in accordance with the Health Insurance Portability and Accountability Act (HIPAA). Please refer to the Notice of Privacy Practices in your Intake Packet for detailed information regarding HIPAA and its application to your personal health information.

Your written authorization is required for the release of information about your treatment, except under the following conditions: disclosure is required by law, court order, imminent danger to self or others, suspicion of child abuse or neglect, and/or nonpayment of fees (only billing information will be provided to a collection agency). Parents or legal guardians who have agreed to cover the cost of treatment for their son or daughter will be provided with medical claim forms that include diagnostic and billing information, which may be submitted for insurance reimbursement purposes.

As a young adult whose medical costs are being covered by a parent or guardian (a "paying agent"), however, I may encourage open communication between you and the paying agent. I may also recommend that paying agents be included in some appointments, in order to facilitate open communication. At times, I may determine that it is in your best interest for me to disclose information shared by you in treatment. This information may include, but will not necessarily be limited to: general themes and issues raised in treatment, dates and times of appointments and information regarding the attendance of those appointments, compliance with treatment, and overall success of treatment. Whenever possible, I will discuss with you in advance my intentions to disclose information. I will inform you of any communication I have with the paying agent on your behalf.

Your signature below indicates that you have read and agreed to the terms, procedures, and guidelines above, and serves as acknowledgment of receipt of the Notice of Privacy Practices and consent to the HIPAA guidelines.

Name Date

Signature

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Authorization for the Release of Information

If you are over 18 years old and will not be personally responsible for all payments made to Karin Varblow, MD, PC, please complete the following form and provide the name and contact information for whomever will be the financially responsible party.

I, _____ , hereby authorize and give consent for the
(Name)

exchange of information between Karin Varblow, MD

And

_____(Name of Parent/Guardian)

_____ (email address)

_____(phone #)

Regarding my personal health information for the purpose of evaluation, treatment, and coordination of care.

This authorization for the release of information will expire on _____ (date) or 90 days after the termination of treatment, whichever comes first.

Signature: _____

Date: _____