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Demographics Patient Information Form

PATIENT INFORMATION

Child's Name (Last Name, First Name, Middle Name) _____ Male (☐) Female (☐)

Date of Birth (Month/Day/Year) ____/____/____ SSN #____-____-____

Child Lives With: ☐Mother ☐Father ☐Guardian/Other:_____ Phone #:_____

Child's Street Address (City, State, Zip Code): _____

Preferred Pharmacy Name:_____Cross Streets: _____ Pediatrician / PCP:_____Phone #: _____

School District: _____, _____ School Name _____ Ethnicity (Please select appropriate group): ☐Latino/Hispanic ☐Decline to Answer

Race (Select appropriate group): ☐ American Indian/Alaska Native ☐Asian ☐ Black/African American ☐Native Hawaiian/Other Pacific Islander☐ White/Caucasian ☐Other

PARENT/GUARDIAN INFORMATION

Parent/Guardian's Name:_____Primary Phone: _____ Alternate Phone: _____

Guardian's Date of Birth: ____/____/____ Email: _____ OPT Out of email contact: ☐ YES

EMERGENCY CONTACT- In case of an emergency, who should we contact? _____ Phone: _____

Relationship: _____ Children's Health Pediatric Group may disclose *Medical* and *Billing* information to this contact. ☐ YES ☐ NO

INSURANCE INFORMATION

Is the patient covered by insurance? ☐YES ☐ NO Is the Patient covered by Medicaid Insurance: ☐ YES ☐ NO

Name of Person Responsible for Paying the Bill ☐ Mother ☐ Father ☐ Other: _____ Primary Phone Number: _____

Street Address: ☐ Same As Child ☐ Other (City, State, Zip Code) _____

Insurance Policy Holder's Name ☐ Child ☐ Mother ☐ Father ☐ Other: _____ Date of Birth:____/____/____

Employer: _____ Insurance Name: _____ Phone #: _____

Insurance ID#: _____ Group #: _____

Patient Name: _____ Date of Birth: _____

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CHILDREN'S HEALTH SYSTEM OF TEXAS

General Consent for School Health Telemedicine Services and Treatment and Acknowledgements

Consent for School Health Telemedicine Care and Treatment

General Consent: I request and consent for Children's Health Pediatric Group ("CHPG"), an entity of Children's Health System of Texas ("Children's Health"), and its physicians and other health care providers to examine Patient, which may be defined as me, my child, or a child for whom I have a legal guardianship, and provide care and treatment through School Health Telemedicine Services, which may include the evaluation, diagnosis, consultation on and treatment of Patient's medical condition using advanced telecommunications technology ("Telemedicine Services"). I agree that by signing this form, I consent for Patient to receive Telemedicine Services in my absence. I understand that the practitioners providing Telemedicine Services at CHPG may include Patient's treating physicians and consultants and such associates, technical assistants and other health care providers as deemed necessary (the "Telemedicine Providers"). I understand that CHPG is a teaching institution and agree that resident physicians, fellows, and students may observe and participate in the Telemedicine Services under appropriate supervision.

I understand that Telemedicine Services include interactive audio, video or other electronic media and that there are both risks and benefits to being treated via Telemedicine. I understand that Telemedicine Providers (i) may be in a location other than where Patient is located, (ii) will examine Patient face-to-face via a remote presence but will not perform a "hands-on" physical examination while using the Telemedicine Services, and (iii) must rely on information provided by Patient and any other health care providers on site. I further understand that Telemedicine Services may be limited or unavailable as a result of technological or equipment failures, incomplete or inaccurate data to perform the Telemedicine Services or distortions of images or other information from electronic transmissions. I acknowledge that the Telemedicine Providers cannot be held liable for advice, recommendations and/or decisions based on factors not within their control, such as incomplete or inaccurate data provided by Patient/others or distortions of diagnostic images or specimens that may result from electronic transmission. I further acknowledge that no guarantees or warranties have been made with respect to Telemedicine Services to be provided. I understand that all supplies, medical devices and other goods provided to Patient are provided by CHPG **AS IS** and Children's Health and CHPG disclaim any expressed or implied warranties.

If the Telemedicine Providers determine that Telemedicine Services do not adequately address Patient's medical needs, the Telemedicine Provider will refer Patient for on-site medical evaluation at a CHPG clinic or other provider location. If after the Telemedicine Services, Patient experiences an urgent or emergent matter, such as a negative reaction to any treatment, or if the telemedicine session is interrupted due to a technological or equipment failure, alternative means of communication and treatment may be needed and I will consult with Patient's providers to obtain follow up care and assistance as needed.

I consent and authorize CHPG Telemedicine Providers to audio record, video record, and/or still photograph the Telemedicine Services. I understand that any part of Patient's body may be included in these visual displays. I agree that these recordings will remain the property of CHPG Telemedicine Providers and may or may not become part of the medical record. I understand that these Telemedicine Services may be viewed by certain medical and non-medical persons for informational, research, and educational purposes. I understand that precautions are taken to protect the confidentiality of Patient's medical information by preventing unauthorized disclosure; however, I understand and acknowledge that the security of electronic transmission of data, video images, and audio information cannot be guaranteed and confidentiality may be compromised by illegal or improper tampering.

Text Messaging: I understand that CHPG can provide notifications to my cell phone. These texts are Do Not Reply texts for informational purposes only and are not intended as a form of two-way communication. I acknowledge that standard text messaging rates and fees will apply, text messaging utilizes a public telephone network and full security is not guaranteed, and any person with access to my phone will be able to see these messages unless I take steps to protect my phone with a password or PIN. I ☐ DO / ☐ DO NOT authorize CHPG to send text messages to the cell phone number I provide for that purpose.

Duration of Consent: I understand and agree this Consent for Telemedicine Services and Treatment is valid for the 2016-2017} school year unless I revoke the consent prior to that time by providing written notice to CHPG at 2777 North Stemmons Fwy. Floor 4, Dallas, Texas 75207

I certify that I have read and understand the information in this General Consent for School Health Telemedicine Services and Treatment form.

_____ _____ _____
Signature of Patient/Parent or Legally Authorized Representative* Date Time

_____ _____
Printed Name of Patient/Parent or Legally Authorized Representative Relationship to Patient

_____ _____ _____
Witness Date Time

_____
Witness Printed Name

***Parent or Legally Authorized Representative must sign if Patient is under 18 years of age.**

Patient Name: _____ Date of Birth: _____

Acknowledgments: Protected Health Information - Notice of Privacy Practices: Children's Health *Notice of Privacy Practices* addresses how Children's Health may use and disclose Patient's Protected Health Information (PHI) for treatment, payment, and healthcare operations and for other purposes allowed or required by law. I acknowledge that I have received the Children's Health *Notice of Privacy Practices* and that any questions or concerns may be directed to the Children's Health Privacy Officer.

Use and Disclosure of information: I understand that Patient's medical records are confidential and cannot be disclosed without my written authorization except as authorized by law. Authorized disclosures are addressed in the Notice of Privacy Practices. I understand that Patient's medical information includes past, present and future information and may include genetic testing / counseling, communicable disease information including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), records related to mental health treatment/psychiatric care and alcohol/substance abuse diagnosis or treatment ("Medical Information"). I authorize release of that Medical Information as part of Patient's medical record. I understand that Children's Health must keep Patient's medical records for a time period required by law and then may dispose of such medical records as permitted or required by law.

Electronic Sharing of Medical Information: I authorize Children's Health to use Patient's Medical Information for the purposes of treatment, payment, regular healthcare operations (collectively referred to as "Purposes"), or as otherwise allowed by law. I acknowledge that Children's Health will release and send, electronically or otherwise, Patient's Medical Information to third parties for the Purposes set forth above, or as otherwise allowed by law. I understand that Medical Information may no longer be protected by federal and state privacy laws once it is disclosed, and, therefore, may be subject to re-disclosure by the recipient. Medical Information may become part of Patient's medical records kept at non-Children's Health healthcare providers and may be further disclosed.

Health Information Exchange: Children's Health participates in Health Information Exchange programs ("HIE(s)") to store and exchange Patient's Medical Information. Patient's Medical Information from non-Children's Health healthcare providers may also be stored and shared in HIE(s), and Children's Health and these other providers can use HIE(s) to see Patient's Medical Information for the Purposes set forth above, to coordinate Patient's care, and as allowed by law. I understand that Patient may opt out of HIE(s) Medical Information sharing by indicating that decision below. Patient may opt back in to HIE(s) Medical Information sharing at any time. I understand that even if Patient opts out of HIE(s) Medical Information sharing, Patient's Medical Information will still be stored in HIE(s). I understand that Patient does not have to participate in HIE(s) Medical Information sharing to receive care.
☐ I do **not** want Patient's Medical Information shared in HIE(s). I understand, however, that if Medical Information sharing with HIE(s) is required by law, Children's Health must act in compliance with the law. I further understand that certain Medical Information may be shared with HIE(s) in a manner that does not identify Patient.

Financial Responsibility and Assignments - Financial Responsibility: I agree to pay for the full billed charges associated with goods and services provided to Patient regardless of any applicable insurance or benefit payments and understand that all amounts are due upon request and are payable to Children's Health and any provider who provides services to Patient at Children's Health (the "Provider(s)"). Except as prohibited by law, I agree to pay for any charges not covered and covered charges not paid in full by any applicable insurance and/or benefit plan including charges payable as co-insurance, deductibles, and non-covered benefits due to policy and / or plan limitations, exclusions, and/or failure to comply with insurance and/or plan requirements. An estimate of the anticipated charges is available upon request. I understand that estimates may vary significantly from the final charges because of a variety of factors such as the course of treatment, intensity of care, Provider practices, and the need to provide additional goods and services. I also agree and understand that if Patient's account becomes delinquent and is referred to an attorney or agency for collection or suit, I will be responsible for paying all charges, reasonable attorney fees, costs, and collection expenses. I consent to credit bureau inquiries and to receiving auto-dialed, computer generated and pre-recorded message calls to my cellular telephone and to any telephone number provided during Patient's registration process from Children's Health, Providers, and their affiliates and agents including, without limitation, any account management companies, independent contractors, or collection agents.

Medicare / Medicaid Patients Only: I understand that the goods and services that I request to be provided to Patient may not be covered under Medicare/Medicaid as being reasonable and medically necessary for Patient's care. I understand that Medicare/Medicaid or their insuring agent determine the medical necessity of the goods and services requested for Patient. If Medicare/Medicaid determines that certain goods and services are not medically necessary for Patient's care and I request such goods and services be provided despite Medicare/Medicaid's denial, I understand I am solely responsible for payment for those goods and services. If Patient is a Medicare/Medicaid managed care Patient, these provisions may not apply. I certify that the information given by or on behalf of Patient in applying for payment under Medicare/Medicaid is correct. I authorize the release of medical or other information about Patient to the Social Security Administration, intermediaries, or carriers as needed for Medicare/Medicaid claims.

Notice to Patients - Third Party Payor (Health Plan Member) Information:
I acknowledge that based on the information I have provided about Patient's third-party payor coverage, insurance, or benefit plan, Children's Health
☐ IS / ☐ IS NOT a participating provider under Patient's third-party payor coverage, insurance, or benefit plan.

Assignment of Benefits: I irrevocably assign and convey directly to Children's Health, and any Provider, all benefits and all interest and rights, including any causes of action, ERISA (Employee Retirement Income Security Act) breach claim or other legal/administrative claim and the right to enforce payment, under any insurance policies, benefit plans, indemnity plans, prepaid health plans, third-party liability policies, or from another payor providing benefits on Patient's behalf for goods and services provided to Patient by Children's Health and Providers. I also authorize direct payment to Children's Health and Providers for the goods and services Children's Health and Providers provide to Patient. I authorize Patient's plan administrator, insurer, and/or attorney to release to Children's Health and Providers all plan documents, summary benefit description, insurance policy, and settlement information upon written request from Children's Health or Providers needed to claim medical benefits.
Under this assignment, I convey to Children's Health and Providers all of my rights to claim or place a lien on benefits related to goods and services provided by Children's Health and Providers to Patient, including rights to any settlement, insurance or applicable legal or administrative remedies, including damages arising from ERISA breach claims, and the right to appeal or pursue any denied or delayed claims. Children's Health and Providers have the right to: (1) obtain all information regarding the claim; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; and/or (5) participate in any administrative and judicial actions and pursue claims, a cause of action, or right against any liable party, insurance company, benefit plan, or plan administrator. Children's Health and Providers may bring suit against any such benefit plan, plan administrator or insurance company in my name and/or Patient's name with derivative standing. This assignment is not and shall not be construed as an obligation of Children's Health and/or Providers to pursue such interest and rights.

I certify that I have read and understand the information in the Acknowledgments for Protected Health Information and Financial Responsibility and have received Children's Health's Notice of Privacy Practices.

_____
Signature of Patient/Parent or Legally Authorized Representative* Date Time

_____
Printed Name of Patient/Parent or Legally Authorized Representative Relationship to Patient

_____
Witness Date Time

_____
Witness Printed Name

***Parent or Legally Authorized Representative must sign if Patient is under 18 years of age.**

children's health
Pediatric Group

Notice of Privacy Practices Effective Date: April 30, 2013 THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. Children's Medical Center of Dallas and its subsidiaries (Children's) takes the privacy of your/your child's (your) health information seriously. We are required by law to keep your health information private, provide you with this Notice of Privacy Practices (Notice), and make a good faith effort to obtain a signed document acknowledging your receipt of this Notice. This Notice provides information about how your medical information may be used and disclosed and describes your rights and our obligations. We are required to abide by the terms of the Notice currently in effect. The Notice will be posted in clear and prominent locations and on our website (www.childrens.com). Any changes made to the Notice will be posted in the Patient Registration area, posted on our website, and the revised Notice will be provided to you upon request. If you have any questions about this Notice, please contact Children's Privacy Officer at 214.456.4444. Thank you, Privacy Officer Children's Medical Center of Dallas This Notice explains how Children's, its employees, medical/dental staff, students and trainees, volunteers, all departments and clinics, and other healthcare providers whose names will be made available upon request, may use and provide your Protected Health Information (PHI) to others for treatment, payment, and healthcare operations as described below, and for other purposes allowed or required by law. PHI is information that you provide Children's or that we create or receive about your healthcare. PHI contains a patient's age, race, gender, and other personal health information that may identify the patient. The information relates to the patient's past, present, or future physical or mental health and to related treatment, services, and payment for care. Understanding Your Health Information Each time you visit Children's, a record of your visit is made in order to manage the care you receive. Children's understands that PHI is personal, and the confidentiality of PHI is protected under both state and federal law. Children's has an electronic health record and will not use or release your PHI without your written authorization, except as described in this Notice. Use or disclosure pursuant to this Notice may include electronic transfer of your PHI. Breach Notification In certain instances, you have the right to be notified in the event that Children's, or one of our business associates, discovers an unauthorized use or disclosure of your unsecured health information. Notice of any such use or disclosure will be made as required by state and federal law. Children's Use and Release of PHI Without Your Authorization The following section explains the various purposes Children's is permitted to use and release PHI. Treatment Purposes In providing healthcare services at Children's, your PHI may be shared with your treating healthcare providers to the extent necessary to provide treatment and care to you. These healthcare providers may include doctors, nurses, pharmacists, labs, and other healthcare providers who are involved in your care both at Children's and at outside healthcare providers. Payment Purposes Children's may need to share your PHI in connection with payment for services you receive. For example, Children's may contact and share information with an insurance company, a government program, or other third parties to determine eligibility status, obtain prior approval, determine if your health plan will pay for treatment, and to file claims. Healthcare Operations Purposes Children's may use and release your PHI for general healthcare operations purposes, including the following: • Quality Improvement Activities: Information may be shared to improve the quality or cost of care. For example, your PHI may be reviewed by Children's or outside agencies to evaluate and improve the quality of care and services we provide. • Medical Residents, Students and Trainees (Students) and Volunteers: Students and volunteers may have access to your PHI for training, education, and service purposes as they participate in educational programs, training, internships, residency programs, or Children's volunteer program. • Appointment Reminders: Children's may provide you with appointment reminders and inform you of treatment alternatives, benefits, or services related to your health. • Care Everywhere Program: Your PHI is kept in an electronic format and may be electronically shared with certain Children's healthcare partners. Care Everywhere is designed to link participating facilities so that those facilities may have access to your PHI to coordinate care more easily. Participation is voluntary, unless required by law, and you may opt out of participation at any time by noting this on the Protected Health Information section of the General Consent for Treatment and Acknowledgements form that you complete at registration or by contacting Children's Privacy Office. If you opt out, your PHI will not be electronically shared with other healthcare partners. You can change your mind or withdraw consent at any time, unless disclosure is required by law; however, Children's cannot take back information that has already been shared. • Health Information Exchange: Your electronic medical records may be shared with electronic Health Information Exchanges (HIEs) (sometimes referred to as Regional Health Information Organizations or RHIOs). Participation is voluntary, unless required by law, and you may opt out of participation at any time by noting this on the Protected Health Information section of the General Consent for Treatment and Acknowledgements form that you complete at registration or by contacting Children's Privacy Office. If you opt out, identifiable PHI will not be shared with an HIE, unless required by law. An HIE is helpful if you require treatment at another facility that participates with Children's in an HIE because it enables the other facility to gather PHI through the HIE to obtain your medical history and coordinate care. Unless disclosure is required by law, you can change your mind and withdraw consent at any time; however, Children's cannot take back information that has already been shared. • Business Associates: There are some services that Children's provides through contracts with third party business associates. Examples include transcription agencies and copying services. Your PHI may be disclosed to our business associates to perform the services they have been contracted to perform. To protect your PHI, Children's requires these business associates to appropriately protect your PHI in compliance with all laws. • Hospital Directory: Unless you object, Children's may include certain limited information about you in the hospital directory while you are in the hospital. This information may include your name, location in the hospital, general condition (for example: good, stable, critical, etc.), and religion. This information may be provided to members of the clergy. This information, except for religious affiliation, may also be provided to people who contact the hospital and ask for you by name. If you do not wish to be included in the hospital directory, please check the box on the General Consent for Treatment and Acknowledgements form under Directory Information requesting you be designated a "no information patient." • Continuity of Care: Once you have been discharged, your information may be shared with other healthcare providers such as home health agencies and community services agencies in order to obtain their services on your behalf. Also, we may use your PHI to contact you with information about disease prevention and health management. Other Disclosure Purposes • Required by Law: Children's must report certain parts of your PHI to legal officials or authorities, including law enforcement, the court system, or government agencies. Examples include: reporting suspected abuse or neglect, domestic violence, or certain physical injuries, and responding to a court order, subpoena, warrant, or lawsuit request. • Public Health: Children's may be required to report certain parts of your PHI to public health authorities. Examples include reporting certain diseases, injuries, and birth or death information. Children's may also be required to report certain information to the Food and Drug Administration (FDA), or information related to child abuse or neglect. • Health Oversight Agencies: Children's may be required to release certain information to state or federal agencies so they can monitor, investigate, or discipline those who work in the healthcare system. • Research Purposes: Children's may use or release your PHI for research purposes. If you are involved in a research study, there will be a

children'shealth
Pediatric Group

specific approval process which includes your authorization to participate. In some instances, PHI may be used without your authorization, but your identifying information will not be released without your authorization. • Notification/Disaster Relief: Children's may use or release your PHI for disaster relief efforts. • Activities Related to Death: Children's may release your PHI for organ and tissue donation or to coroners, medical examiners, or funeral directors so they can carry out their duties related to death. Examples include: determining cause of death, and carrying out funeral preparation activities. • To Avoid Serious Threat to Health or Safety: Children's may use and disclose your PHI to the proper authorities when necessary to prevent a serious threat to the health and safety of the public or another person. • Military: Children's may release your PHI to the proper requesting authorities if you are a member of the armed forces. • Law Enforcement Custody or National Security: Children's may release your PHI to a correctional institute or law enforcement official if you are under the custody of state or federal law enforcement officials or incarcerated, for the purpose of providing you with healthcare, to protect your health and safety or the health and safety of others, or for the safety and security of the law enforcement official or correctional institute. • Workers' Compensation: Children's may be required to release your PHI regarding workers' compensation benefits and activities. • Fundraising: Children's may use your limited PHI to contact you regarding fundraising for the purpose of and in conjunction with Children's mission to provide healthcare and make life better for children. You have the right not to receive these communications. You may contact the Privacy Office if you want to exercise your right to not receive these communications. Children's will not condition your treatment on whether you have agreed to receive fundraising communications. • Marketing: Children's may only use your PHI for limited marketing purposes as follows: face-toface communications, promotional gifts of nominal value, refill reminders, or to otherwise tell you about a drug related to your treatment or our healthcare operations as described in this Notice. Examples of these communications include: case management, care coordination, or treatment alternatives that may be available. Releases of Your PHI that Require Your Authorization Your authorization is needed for other uses and disclosures of your PHI, except for the types of examples included under the exceptions described above. This includes, unless otherwise required by law, release of psychotherapy notes, broader marketing purposes, sale of your PHI, HIV/AIDS information, substance abuse treatment records, and deceased patients' records. If you provide Children's the authorization to use or release your PHI, you may revoke that authorization at any time; however, Children's cannot take back information that has already been shared. The authorization can be revoked by following the instructions described on the Authorization for the Inspection, Use, Disclosure and Release of Health Information form which can be obtained on our website at www.childrens.com or by contacting the Privacy Office. Your Privacy Rights Your rights regarding your PHI are as follows: Right to receive this Notice of Privacy Practices You have the right to receive a copy of this Notice at any time. You may obtain a paper copy of the current notice in all clinical areas or an electronic copy by visiting Children's website at www.childrens.com. Right to review and ask for a copy of your PHI You have the right to review and request copies of your medical records that may be used to make decisions about your care. Usually this includes medical and billing records, but there may be exceptions for psychotherapy notes or information about third parties. You may request a paper or electronic copy of your medical record by visiting our Health Information Management department, by completing the Authorization for the Inspection, Use, Disclosure and Release of Health Information form located at www.childrens.com, or by contacting the Privacy Office. Also, you can sign up for a MyChart account, which allows you to electronically access portions of your health information at www.childrens.com. Children's may charge you a fee to copy and/or mail your medical record to you as permitted by law. If we are able, we will provide an electronic copy to you within 15 days of your written request and receipt of appropriate fees. Right to request confidential communications You have the right to specify that Children's communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by telephone at work, or that we only contact you by mail at home or by email. We will follow your request whenever it is reasonably possible. You can request an alternate place for communication by completing the form Request for Alternative Communication of Health Information at the time of registration, or on Children's website at www.childrens.com, or by contacting the Privacy Office at 214.456.4444 to request an alternate place for communication. Right to request restrictions You have the right to request restrictions or limitations on how your PHI is used or released. We have the right to deny your request, except we must agree when the disclosure of PHI would be to a health plan if the disclosure of PHI is for payment or healthcare operations and is not otherwise required by law, and if the PHI is for a healthcare item or service which was paid in full by you, or was paid in full by a person, other than health plan, on your behalf. You can complete the form Request for Restricting the Use or Disclosure of Health Information which can be found at www.childrens.com or by contacting the Privacy Office at 214.456.4444. Right to Amend You have the right to ask that your medical record at Children's be changed if it is not correct or complete. Children's does have the right to deny your request if: we did not create the information; we do not keep the information; you are not allowed to see and copy the information; or the information is already correct and complete. You may request a change by completing the form Request for an Amendment of Health Information which can be found at www.childrens.com or by contacting the Privacy Office at 214.456.4444. Right to a Record of Releases You have the right to request a record of releases (accounting of disclosures) when Children's has disclosed your PHI. You can request a record of releases of your PHI by submitting the form Request for an Accounting of Disclosures of Health Information to the Health Information Management Department. This form can be found at www.childrens.com or by contacting the Privacy Office at 214.456.4444. If you request this record of releases more than once per year, Children's may charge a fee for providing the list. The list will contain only information that is required by law. This list will not include releases for treatment, payment, and healthcare operations, or releases that you have authorized. Questions or Complaints If you have questions regarding your privacy rights, please call Children's Privacy Office. If you believe your privacy rights have been violated, you may file a complaint by contacting Children's Privacy Officer through Children's HIPAA Hotline at 214.456.4444, by e-mail at privacy@childrens.com, or with the Secretary of Health and Human Services. You will not be penalized for filing a complaint. **Privacy Officer Contact Information: Privacy Officer Children's Medical Center of Dallas 1935 Medical District Drive Dallas, TX 75235 214.456.4444**

To obtain a complete copy of records from a telemedicine services visit, you may access via MyChart or must request those records from the Children's Health - Health Information Management department at 214-456-2509.