

**PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS - HIPAA**



I, \_\_\_\_\_, understand that as part of my child's/children's health care, All About Children Pediatrics originates and maintains paper and/or electronic records describing their health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my child's/children's care and treatment;
- A means of communication among the many health professionals who contribute to my child's/children's care;
- A source of information for applying my child's/children's diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information and Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my child's/children's health information for directory purposes, and
- The right to request restrictions as to how my child's/children's health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that All About Children Pediatrics is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat my child/children as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that All About Children Pediatrics reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should All About Children Pediatrics change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my child's/children's health information:

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I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my child's/children's protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Parent/Guardian Printed Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date