CONSENT TO USE AND DISCLOSURE OF INFORMATION FOR TREATMENT, PAYMENT OR OPERATIONS

I hereby consent to the use and disclosure of information in my medical records for treatment, payment and health care operations purposes. I understand that this consent is voluntary. I understand that information in my medical records may be used and disclosed to persons other than Helping Hands Pediatrics, Inc. to carry out their responsibilities in connection with my medical/health care treatment, in payment for health care services rendered to me and in activities related to health care operations.

Initials: _____

I understand that additional information on Helping Hands Pediatrics, Inc. privacy practices related to my medical records is available from the Helping Hands Pediatrics' comprehensive Notice of Privacy Practices, a copy of which has been made available to me, and which I have read or do not wish to read, prior to signing this consent.

Initials: _____

I understand that I may request Helping Hands Pediatrics to restrict how or to whom my medical records are used or disclosed, but that Helping Hands Pediatrics may refuse the restriction I request. However, if Helping Hands Pediatrics agrees to the restrictions, it is bound to them when disclosing information in my medical records.

Initials: _____

I understand that I can revoke this consent at any time, by notifying Helping Hands Pediatrics in writing, but if I do, it won't have an effect on actions Helping Hands Pediatrics took before they received the notifications.

Initials: _____

I understand that this consent applies to the use and disclosure of information for treatment, payment or operations purposes only and that Helping Hands Pediatrics may decline to provide medical/health care services to me if I do not sign it.

Initials: _____

I give my consent for all necessary school forms and/or immunization records to be faxed to my child's school and/or daycare facility.

Initials: _____

_____ _____

Signature of Patient or Patient's Representative Date

Printed Name of Patient's Representative: _____

Relationship to Patient: _____