



PEDIATRIC PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my child's protected health information. These rights are given to me under the Health Insurance Portability Accountability ACT of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my child's protected health information to carry out the following:

- Treatment (including direct or indirect by other healthcare providers involved in the treatment plan)
- Obtaining payment from third party payers (e.g. insurance companies)
- The day to day healthcare operations of your office

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains the more complete description of the uses and disclosure of any protected health information and my rights under HIPAA. I understand you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my child's protected health information is used and disclosed to carry out treatment or pay the healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, then you are bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date that I revoke this consent is not affected.

Signed this _____ day of _____, 20_____

Print PATIENT Name _____

Relationship to Patient _____

Signature _____

I understand that I will be responsible for payment of all services if any of the following circumstances apply and agree to pay:

- If the patient does NOT have Insurance.
- If patients are with an insurance company that we are NOT contracted with
- If the patient's insurance company denies any claim for any reason that is not resolvable

Responsible Party Signature _____ Date _____