New Patient Consent to the Use and Disclosure of Health Information

I understand that as part of my child's health care, Professional Park Pediatrics originates and maintains paper and/or electronic records describing my child's health history, symptoms, examination, test results, diagnoses, treatment, and plans for future care or treatment. I understand that this information serves as:

- A basis for planning my child's care and treatment,
- A means of communication among the many healthcare professionals who contribute to my child's care,
- A source of information for applying my diagnosis and surgical information to my child's 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 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, and
- The right to request restrictions as to how my child's health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that Professional Park Pediatrics is not required to agree to the restrictions that I request. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action.

I further understand that Professional Park 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 Professional Park Pediatrics change their notice, they will send a copy of any revised notice to the address I've provided.

I wish to have the following restrictions (ex. Parent or Legal Guardian has sole custody, Only Mom/Dad/Legal Guardian can seek medical care) placed on the use or disclosure of my child's health information:

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

Written Acknowledgment

I am a parent or legal guardian of _____(Patient Name). I hereby acknowledge receipt of Professional Park Pediatrics' Notice of Privacy Practices and Health Information Disclosure Practices with respect to the patient (my child).

Signature:_____ Date:_____

Name:_____ Relationship (Circle): Parent Guardian