HEALTHY KIDS PEDIATRICS
211 MAIN STREET
PORT WASHINGTON, NY 11050

PATIENT CONSENT FORM

With my consent, Healthy Kids Pediatrics may use and disclose protected health information (PHI) about me/my child to carry out treatment, payment, and healthcare operations (TPO). Please refer to Healthy Kids Pediatrics' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I understand that, under the Health Insurance Portability Accountability of 1996, I have certain rights to privacy in regards to my/my child's PHI. I have received, read, and understand the Notice of Privacy Practice.

Healthy Kids Pediatrics reserves the right to revise its Notice of Privacy Practices at any time. Should I wish to review the revised Notice of Privacy Practice, it may be obtained by forwarding a written request to Healthy Kids Pediatrics at the address above.

With my consent, Healthy Kids Pediatrics may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my/my child's clinical care, including laboratory results among others.

With my consent, Healthy Kids Pediatrics may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that Healthy Kids Pediatrics restrict how it uses my/my child's PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Healthy Kids Pediatrics' use and disclosure of my/my child's PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Healthy Kids Pediatrics has the right to decline to provide treatment to me/my child, other than emergent care, if they choose to.

Patient Name:________________________ Date of Birth:_____________

Signature:___________________________ Date:_____/______/______