Eden Park Pediatric Associates

Consent to Use & Disclose Health Information

This office is required by Federal Regulations to inform our Patients in regards to the use of your child's health information in accordance to Health Insurance Portability & Accountability Act of 1996 of HIPPA.

Please read the following information carefully:

I understand as part of my health care, Eden Park Pediatric Associates originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnosis, treatments and any plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment.
- A means of communication among health professionals who contribute to my care.
- A source of information for applying my diagnosis and treatment information to my bill.
- A means by which a third-party can verify the services billed to me actually took place.

I understand and have been provided access to a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. This notice is located in the waiting area in plain view. I understand that I have the following rights and privileges:

- The right to review the *Notice of Privacy Practices* prior to signing this consent, allowing treatment, or making payment for services rendered.
- The right to object to the use of my child's health information for directory purposes.

I understand that Eden Park Pediatric Associates 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 may refuse to treat me as permitted by Federal Regulations. I understand that Eden Park Pediatric Associates reserve the right to change their *Notice of Privacy Practices*. I further understand that Eden Park Pediatric Associates uses a computerized state vaccine registry to track immunization requirements and maintain immunization records. We will enroll you UNLESS you inform us in writing that you do NOT wish to participate.

Please note that I, ________________, consent to the following uses of my medical information (initial below):

______ I allow my parents access to my diagnosis and treatment information as it applies to any charges I incur at Eden Park Pediatric Associates.
______ I allow my immunization record to be faxed or mailed to my school.
______ I allow my immunization records to be faxed or mailed to my parents.
______ I allow my parents complete access to my medical records.
______ Other: ____________________________________

I understand that as part of this organizations treatment, payment, or health care operation, it may become necessary to disclose my protected health information to another entity. I hereby consent to such disclosure for these permitted uses. I, also, hereby consent to such disclosures via fax.

I fully understand and accept the terms of this consent.

____________________________________ __________

Signature Date