HIPAA

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

Your protected health information will be used by Sunshine Valley Pediatrics (SVP) or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day to day health care operations of the practice.

NOTICE OF PRIVACY PRACTICES
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

REQUESTING A RESTRICTION ON THE USE OR DISCLOSURE OF YOUR INFORMATION
You may request a restriction on the use or disclosure of your protected health information. SVP may or may not agree to restrict the use or disclosure of your protected health information. If SVP agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

REVOCATION OF CONSENT
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

RESERVATION OF RIGHT TO CHANGE PRIVACY PRACTICES
SVP reserves the right to modify the privacy practices outlined in the notice.

AUTHORIZED PERSONS TO RECEIVE DISCLOSED INFORMATION: (May call SVP and receive verbal information about patient, may receive laboratory and other medical related information from SVP)

NAME OF AUTHORIZED PERSON TO ACCESS MEDICAL RECORDS	RELATIONSHIP: (PARENT/AUNT/UNCLE, etc.)
1.	
2.	
3.	
4.	
5.	

Signature: I have reviewed this consent form and give my permission to SVP to use and disclose my health information in accordance with it.

____
Name of Patient (Print or Type) Date:

____
Signature of Patient/Patient Representative/ Relationship to Patient