CHILDREN'S MEDICAL CENTER
Practice Limited to
Infants, Children and Young Adults

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Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information.

These rights are given to me under the **Health Insurance Portability and Accountability Act of 1996 (HIPAA).** I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment, including direct or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment for services rendered.
- The day-to-day healthcare operation of your practice.

I have also been informed or given a right to review or secure a copy of your Notice of Privacy Practices, which contain a more complete description of the uses and disclosures of my protected health information and my right under HIPAA. I understand that 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 restriction on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to this restriction request. However, if you do agree, you are then 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 I revoke this consent is not affected.

Please print the names and dates of birth for all patients in family_____

_____

_____

Signature: _____

Relationship to Patient: _____

Date: _____

*Notice of Privacy Practices for Protected Health Information is available on the website www.cmcpediatrics.com or by requesting a copy from office staff.