RTC Pediatrics
We care for kids

Reston Town Center Pediatrics
Patient Consent for Use and Disclosure of Protected Health Information (PHI) and Practice Privacy Policy (HIPAA)

I hereby give my consent to Reston Town Center Pediatrics (RTC Peds) to use and disclose Protected Health Information (PHI) about me/my child to carry out treatment, payment, and healthcare operations. RTC Peds' Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. RTC Peds reserves the right to revise its Notice of Privacy Practices at any time. A copy of the Notice of Privacy Practices may be obtained at our Front Desk, or our website: www.rtcpeds.com – Forms Section.

By signing this form, I acknowledge receipt of the office Notice of Privacy Practices. I also consent to allowing RTC Peds to call, email, fax or mail my home or any other alternative contact point I provide and leave a message on voice mail, in person or in writing, in reference to any items that assist the Practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance issues, and clinical care (including testing results). I understand that I have the right to request that RTC Peds restricts how it uses or discloses my PHI to carry out treatment, payment, and healthcare operations. The practice does not have to agree to my requested restrictions, but if it does, it is bound by the agreement. All requests for restrictions must be submitted in writing.

By adding names to the bottom of this form – I agree that they are allowed to receive PHI in the same manner as described above (with the exception of information relating to STD, HIV/AIDS, Pregnancy testing and records relating to drug, alcohol or mental health treatment which all require an additional release).

I may revoke my consent in writing except to the extent that the Practice has already made disclosures in reliance upon my prior consent. I understand that if I do not sign this consent, or later revoke it, RTC Peds may decline to provide treatment to me/my child.

_____ _____ _____
Patient Name Date of Birth Today's Date

_____ _____
Signature of Parent/Legal Guardian/Patient Printed Name of Parent/Legal Guardian

******If the patient is over 18 years of age, they must sign for themselves.***

Additional HIPAA Approved Contact(s):

_____ _____
Name/Relationship to patient Name/Relationship to patient

_____ _____
Name/Relationship to patient Name/Relationship to patient

If Over 18 _____ (phone#) _____ (email)