PEDIATRIC ASSOCIATES MEDICAL GROUP, INC.
PRACTICE LIMITED TO INFANTS, CHILDREN, AND ADOLESCENTS

HIPAA CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you or your child. This Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you or your child is used or disclosed for treatment, payment, or health care operations.

By signing this form, you consent to our use and disclosure of protected health information about you or your child for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient/legal guardian understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient/legal guardian has the right to restrict the uses of their information.
- The patient/legal guardian may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

I, as the below named patient or parent/legal guardian, have full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment and health care operations.

_____	_____
Name of Patient/Legal Guardian	Relationship to Patient
_____	_____
Signature of Patient/Legal Guardian	Date