MOVIN' & GROOVIN' CHILDREN'S THERAPY SERVICES, INC.

17 Interlochen Drive
Atlanta, GA 30342
Phone (404)-918-1828
Fax (404)-459-8948

Consent to Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I, ____________________, understand that as part of (child' s name)____________________healthcare, this practice originates and maintains health records describing my child's health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my child's care and treatment
- a means of communication among the many health professionals who contribute to my child's care
- a source of information for applying m child's diagnosis, treatment, and surgical information to my bill
- a means by which third-party payer can verify that services billed were actually provided, and
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a Notice of Health Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization, Movin' & Groovin' Children's Therapy Services, Inc., reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I disclosed to carry out treatment, payment, or healthcare operations and that the organization, Movin' & Groovin' Children's Therapy Services, Inc., is not required to agree to restrictions requested. I understand that I may revoke this consent in writing except to the extent that the organization, Movin' & Groovin' Children's Therapy Services, Inc., has already taken action in reliance thereon.

I wish to have the following restrictions to use or with disclosure of my health information:

I fully understand and accept the terms of this consent

Signature of parent or guardian for above named child

Date