Advanced Pediatrics

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CONSENT FOR TREATMENT
PAYMENT AND HEALTH CARE OPERATIONS

I consent to the use or disclosure of my protected health information by Advanced Pediatrics for the purpose of diagnosing or providing treatment to me/my child, obtaining payment for my/my child's health care bills or to conduct health care operations of Advanced Pediatrics.

I have the right to revoke this consent, in writing, at any time, except to the extent that Advanced Pediatrics has taken action in reliance on this consent.

My/my child's "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my/my child's past, present or future physical or mental health or condition and identifies me/my child, or there is a reasonable basis to believe the information may identify me/my child.

ADVANCED PEDIATRICS has an established privacy policy which is displayed in this office and I can request a printed copy of this policy.

x _____ _____

Signature of Patient or Parent / Guardian | Name of Patient

_____ _____

Relationship to Patient | Date