

Clinical Pediatric Associates
8355 Walnut Hill Lane Suite 105 Dallas, TX 75231
Phone: 214-368-3659

PATIENT CONSENT AND ACKNOWLEDGEMENT OF PRIVACY POLICY

I understand that as part of the provision of healthcare services, Clinical Pediatric Associates creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that Clinical Pediatric Associates reserves the right to change their notice and practices and prior implementation will mail a copy of any revised notice to the address I have provided. I understand I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that Clinical Pediatrics is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

I understand that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my protected health information, which is used or disclosed for the purposes of treatment, payment or healthcare operations, be restricted. I also understand that Clinical Pediatrics and I must: agree to any restriction in writing that I request on the use and disclosure of my protected health information which have been previously agreed upon.

Patient(s) Name _____

Guarantor Name or Authorized Representative _____

Signature _____ Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____