BRIGHTON HILL PEDIATRICS, R.L.L.P.

Patient Consent to Treat and Consent to Use and Disclose Health Information for Treatment, Payment, or Healthcare Operations

I consent to the examination and treatment of my children by the physicians and nursing staff of Brighton Hill Pediatrics, R.L.L.P.

I understand that as part of my health care, Brighton Hill Pediatrics, R.L.L.P., originates and maintains paper and/or electronic records describing me and for my children's health history, including, but not limited to, office visits and treatment rendered, clinical laboratory reports, diagnostic test results, x-ray reports, hospital reports, mental health records, HIV reports and confidential chart material. I understand that this information serves as:

• A basis for planning my care and treatment,

• A means of communication among the many health professionals who contribute to my care,

• A source of information for applying my diagnosis and surgical information to my bill,

• A means by which a 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 healthcare professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

• The right to review the notice prior to signing this Consent,

• The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Brighton Hill Pediatrics, R.L.L.P. is not required to agree to the restrictions requested. Should Brighton Hill Pediatrics, R.L.L.P. not agree to my requested restrictions, the practice will so inform me in writing. I understand that I may revoke this Consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sip this Consent or revoking this Consent, Brighton Hill Pediatrics, R.L.L.P., may refuse to treat me.

I further understand that Brighton Hill Pediatrics, R.L.L.P. reserves the right to change their notice and practices in accordance with Section 164.520 of the Code of Federal Regulations. Should Brighton Hill Pediatrics, R.L.L.P. change their notice, it will be provided to me, if I so request it. .

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

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I understand that as part of Brighton Hill Pediatrics, R.L.L.P.'s treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted-uses, including disclosures via fax.

I fully understand the terms of this Consent.

Signed: _____ Date:_____

Children's names (Please Print) _____

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UPDATED 2015