Parent Consent Form_HIPPA

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA),
I have certain right to privacy regarding my protected health information.
I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment, directly and indirectly.

Obtain payment from third party payers. Conduct normal healthcare operations such as quality assessments and physician certificates.

I have been informed by you of your Notice of Privacy Practices containing a more description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this content.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain the address and receive a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment or healthcare operations.

I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound by such restrictions.

I understand that I may revoke this content in writing at any time, except to the extent that you have taken action relying in this consent.

Patient name: ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date: ______________________________