CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I, the undersigned patient, hereby consent to the use or disclosure of individually identifiable health information by Brighton Pediatrics in order to carry out treatment, payment, or health care operations. I have received and reviewed this facility's Notice of Privacy Policy prior to signing this form and hereby acknowledge and understand my rights as indicated therein.

I understand that this facility reserves the right to change the terms of its Notice of Privacy Policy at any time. If the facility does change the terms of its Notice of Privacy Policy, I may obtain a copy of the revised Notice of Privacy Policy by requesting same in writing.

At all times, I retain the right to revoke this consent. Such revocation must be submitted to the facility in writing. The revocation shall be effective except to the extent the facility has already taken action in reliance on this Consent Form.

I understand that this facility may refuse to provide treatment if I or my authorized representative does not sign this Consent Form, except to the extent that the facility is otherwise required by law to provide treatment to individuals. If I or my authorized representative signs this Consent Form and then revokes consent, the facility has the right to refuse to provide further treatment to patient as of the time of the revocation, except as otherwise required by law.

I have read and understand this information. I have received a copy of this form and this facility's Notice of Privacy Policy. I am the patient or I am authorized to act on behalf of the patient to sign this document verifying consent to the above stated terms.

Signature of Parent/Authorized Representative ____

Printed Name of Parent/Authorized Representative _____________________________________

Date ______________________________

Name of Child/Children____

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Please complete both sides →

AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

I, the undersigned patient, hereby authorize the disclosure of individually identifiable health information by Brighton Pediatrics for the purpose of providing information to my school and/or employer. The facility may use or disclose such protected health information for one (1) year from the date indicated herein. I understand that I may refuse to sign this Authorization if I so choose, but I understand such refusal will result in this facility's inability to provide any personal health information, including records and/or notes, on my behalf to my school and/or employer.

At all times, I retain the right to revoke this Authorization, except if the Authorization was obtained as a condition of obtaining insurance coverage. Such revocation must be submitted to this facility in writing. The revocation shall be effective except to the extent that the facility has already used or disclosed information in reliance on the Authorization.

I have been informed and understand that information used or disclosed pursuant to this Authorization may be subject to disclosure by the recipient of such information, and, at that point, the information may no longer be protected under this agreement.

I have read and understand this information. I have received a copy of this form and I am the patient or I am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the protected health information under the above stated terms.

Signature of Parent/Authorized Representative ____

Printed Name of Parent/Authorized Representative _____________________________________

Date _______________________________

Name of Child/Children____

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Please complete both sides