

**Patient Consent to the Use and Disclosure of Health Information
for Treatment, Payment or Healthcare Operations**

I, _____, understand that as part of my healthcare, Lake Area Pediatrics originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. 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 tool for routine healthcare operation such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information 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 object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I understand that Lake Area Pediatrics is not required to agree to the restrictions requested. 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 sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Lake Area Pediatrics reserves the right to change their notice and practices prior to Implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Lake Area Pediatrics change their notice, they will send a copy of any revised notice to the address I have provided.

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

I understand that as part of this organization's treatment, payment or healthcare 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 disclosure via fax and e-mail.

By signing this I fully understand and accept the terms of this consent.

Patient's Name

Date of Birth

Parent of Guardian Signature

Date