

Pediatrics West, P.C.

CONSENT TO DISCLOSE HEALTH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS

Last

First

Middle

Patient Name: _____ Date of birth _____

Patient Name: _____ Date of birth _____

Patient Name: _____ Date of birth _____

Patient Name: _____ Date of birth _____

Home address: _____

E-mail: _____

Phones: Home _____ Work _____ Cell _____

ACKNOWLEDGEMENT OF RECEIPT OF PRACTICE'S NOTICE OF PRIVACY:

By my signature below, I hereby acknowledge that I have been given access to the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), and that I understand the Notice of Privacy Practices. I also understand that a full copy of HIPAA is available upon request.

CONSENT TO DISCLOSE MY GENERAL HEALTH INFORMATION:

By my signature below, I hereby authorize Pediatrics West to disclose my child's medical information so that the Practice may treat my child, seek payment from third parties for such treatment, and generally carry on the Practices' health care operations (e.g., quality assurance). I also authorize the Practice to disclose my child's medical information to insurers and providers outside of the Practice when necessary so that these providers may treat my child and seek payment for that treatment, and for the purpose of their health care operations. I also authorize the Practice to disclose my child's medical information on my home answering machine or voicemail.

The following family members/friends have my permission to accompany my child to his/her medical appointment:

I authorize the Practice to disclose my medical information to the following family members/friends:

I authorize the release of pertinent medical information to my insurance company, and that benefits be paid directly to this office. I understand that I am financially responsible for any services not covered by my insurance and agree to comply with this office's financial policy, including payment in full at the time of service unless other arrangements have been made in advance. I agree that I will also be responsible for any cost of collection, including attorney fees, if it becomes necessary to forward my account to a collection agency.

Signature: _____ Date: _____