CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT, AND HEALTH CARE OPERATIONS

By signing below, you hereby consent for **Starkville Pediatrics** to use and/or disclose information about yourself (or another person for whom you have authority to sign) that is protected under federal law, for the sole purposes of *treatment, payment, and health care operations.* You may refuse to sign this consent form.

You should read the ***Notice of Privacy Practices*** for **PHI** attached to this form before signing the consent. The terms of the Notice may change from time to time, and you may request a revised copy by asking the **Privacy Officer** at **Starkville Pediatrics**.

You have the right to request that **Starkville Pediatrics** restrict how **PHI** is used or disclosed to carry out *treatment, payment, or health care operations*. **Starkville Pediatrics** is not required to agree to requested restrictions; however, if **Starkville Pediatrics** agrees to your requested restriction, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the **Protected Health Information** used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

●You may communicate with the following individual(s) regarding my child's condition or course of treatment: _____.

●You may communicate confidential information to me, including invoices for services, to the following address and/or phone/fax numbers:

_____.

_____ _____
Print Name of Individual or Personal Representative Relationship to Patient

_____ _____
Signature of Individual or Personal Representative Date

●As a personal representative, I have the authority to act for the individual because I am the individual's _____/Name: _____.