

Raleigh Pediatric Associates

CONSENT TO USE & DISCLOSE HEALTH INFORMATION FOR PATIENTS 18 YEARS OLD AND OLDER

This office is required by Federal Regulations to inform our patients in regards to the use of their health information in accordance to Health Insurance Portability & Accountability Act of 1996 or HIPAA.

PLEASE READ THE FOLLOWING CAREFULLY!

I understand that as part of my health care, Raleigh Pediatric Associates originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatments, and any plans for future care or treatment.

I understand and have been provided access to a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the *Notice of Privacy Practices* prior to signing this consent, allowing treatment, or making payment for services rendered.

I understand that Raleigh Pediatric Associates 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 may refuse to treat me as permitted by Federal Regulations. I understand that Raleigh Pediatric Associates reserves the right to change their *Notice of Privacy Practices*.

PATIENT NAME _____

CHART# _____

DATE OF BIRTH: _____

I consent to the following uses of my medical information: (Please choose 1 option below and initial next to your choice)

_____ I allow the following people complete access to my medical records.

_____ Full Name

_____ Relationship

_____ Full Name

_____ Relationship

_____ Full Name

_____ Relationship

OR

_____ I allow the following people access to my diagnosis and treatment information as it applies to any charges I incur at RPA.

_____ Full Name

_____ Relationship

_____ Full Name

_____ Relationship

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity. I hereby consent to such disclosure for these permitted uses. I also hereby consent to such disclosures via fax.

I fully understand and accept the terms of this consent.

Signature

Date