260 SW Natura Ave, STE 102,
Deerfield Beach, FL 33441
Phone 954-505-8524
Fax 954-628-5866

Patient Consent for Use and Disclosure of Protected Health Information & Receipt of Practice Privacy Policy

I hereby give my consent for Penn Pediatrics to use and disclose protected health information (PHI) about me/my child to carry out treatment, payment, and healthcare operations (TPO). Penn Pediatrics' Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Penn Pediatrics reserves the right to revise its Notice of Privacy Practices at any time. A copy of the Notice of Privacy Practices may be obtained at any time by forwarding a written request to Penn Pediatrics' Privacy Officer at 260 SW Natura Ave, STE 102, Deerfield Beach, FL 33441.

By signing this form, I acknowledge receipt of the office Notice of Privacy Practices. I also consent to allowing Penn Pediatrics to call, email, fax or mail my home or any other alternative contact point I provide and leave a message on voice mail, in person or in writing, in reference to any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance issues, and clinical care (including testing results). I understand that I have the right to request that Penn Pediatrics restricts how it uses or discloses my PHI to carry out TPO. The practice does not have to agree to my requested restrictions, but if it does, it is bound by the agreement. All requests for restrictions must be submitted in writing.

By adding names to the bottom of this form – I agree that they are allowed to receive PHI in the same manner as described above (except for information relating to STD, HIV/AIDS, Pregnancy testing and records relating to drug, alcohol or mental health treatment which all require an additional release).

I may revoke my consent in writing except to the extent that the Practice has already made disclosures in reliance upon my prior consent. I understand that if I do not sign this consent, or later revoke it, Penn Pediatrics may decline to provide treatment to me/my child.

_____ _____ _____

Patient Name Date of Birth Today's Date

_____ _____

Signature of Parent/Legal Guardian/Patient Printed Name of Parent/Legal Guardian

***If the patient is over 18 years of age, they must sign for themselves.**

ADDITIONAL HIPAA APPROVED CONTACTS

_____ _____

Name/Relationship to patient Name/Relationship to patient

_____ _____

Name/Relationship to patient Name/Relationship to patient

If Over 18 _____ (phone) _____(email)