Authorization for Treatment and Payment and HIPAA Acknowledgement

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice.

I understand I have the right to request and receive a copy of the HIPAA Privacy Plan for Leon Springs Pediatrics.

I consent to the use or disclosure of my child's/children's protected health information by Leon Springs Pediatrics for the purpose of diagnosing or providing treatment to my child/children, for the purpose of obtaining payment for my healthcare bill, or to conduct healthcare operations at Leon Springs Pediatrics. I understand that diagnosis or treatment by physicians from Leon Springs Pediatrics may be conditional upon my consent as evidence by my signature on this document.

I consent for my primary care physician to obtain a list of prior medications from any pharmacy I may have used for the purpose of continuity of care and to better assist in the care of my child.

I have the right to revoke this consent, in writing, at any time, except to the extent that the physicians of Leon Springs Pediatrics has taken action in reliance on this consent.

I authorize the release of any medical information to process any claims. I permit a copy of this authorization to be used in place of an original.

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Signature

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Print Name of Signature Guarantor

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Date

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Patient Name (s)