MOUNTAIN PEDIATRICS

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Notice of Privacy Practices

Name____________________________________ M ☐ F ☐ DOB_______/_______/_______

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Name____________________________________ M ☐ F ☐ DOB_______/_______/_______

Name____________________________________ M ☐ F ☐ DOB_______/_______/_______

I consent to the use of/or disclosure of me or my child's protected health information by Mountain Pediatrics for the purpose of diagnosing or providing treatment, obtaining payment for health care bills or to conduct healthcare operations of Mountain Pediatrics. I understand that the diagnosis or treatment of my child may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how me or my child's protected health information is used or disclosed to carry out treatment, payment or the healthcare operations of the practice. Mountain Pediatrics is not required to agree to the restrictions that I may request. However, if Mountain Pediatrics agrees to a restriction that I request, the restriction is binding on Mountain Pediatrics.

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

My child's protected health information means health information, including demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to the past, present or future physical or mental health or condition and identifies me or my child. Or if there is a reasonable basis to believe information may identify me or my child.

I understand I have a right to review Mountain Pediatrics Notice of Privacy Practices prior to signing this document. I understand that a copy will be available to me at anytime upon request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my child's treatment, payment of my bills, or in the performance of the healthcare operations of Mountain Pediatrics. The Notice of Privacy Practices also describes my rights and Mountain Pediatrics duties with respect to my protected health information.

Mountain Pediatrics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised copy by contacting the office and requesting a revised copy be sent in the mail or by asking for one at the time of an appointment.

*Print Name*_______________________________________ *Sign Name*______________________________

*Relationship to Patient*_____________________________*Date*____________________________________