Consent for Purposes of Treatment, Payment and Health Care Operations

I, as the patient, parent, guardian or personal representative of the patient, consent to the use or disclosure of the patient's protected health information by East Louisville Pediatrics, PSC for the purpose of diagnosing or providing treatment to the patient, obtaining payment for health care bills or to conduct health care operations of East Louisville Pediatrics, PSC. I understand that diagnosis or treatment of the patient by East Louisville Pediatrics, PSC 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 the patient's protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. East Louisville Pediatrics, PSC is not required to agree to the restrictions that I may request. However, if East Louisville Pediatrics, PSC agrees to a restriction that I request, the restriction is binding on East Louisville Pediatrics, PSC and any healthcare provider of East Louisville Pediatrics, PSC.

I have the right to revoke this consent, in writing, at any time, except to the extent that East Louisville Pediatrics, PSC or any healthcare provider of East Louisville Pediatrics, PSC has taken action in reliance on this consent.

The patients' "protected health information" means health information, including demographic information collected from me, as the patient, parent, guardian or personal representative and created or received by the patient's physician, another health care provider, a health plan, employer or a health care clearinghouse. This protected health information relates to the patient's past, present or future physical or mental health or condition and identifies me/him/her, or there is a reasonable basis to believe the information may identify me/him/her.

I understand I have a right to review, on behalf of the patient, East Louisville Pediatrics, PSC's Notice of Privacy Practices prior to signing this document. The East Louisville Pediatrics, PSC Notice of Privacy Practices has been provided to me, as the patient, patient's parent, guardian or personal representative.

The Notice of Privacy Practices describes the types of uses and disclosures of patient's protected health information that will occur in their treatment, payment of bills or in the performance of health care operations of the East Louisville Pediatrics, PSC.

The Notice of Privacy Practices for East Louisville Pediatrics, PSC is also provided in the office where the Notice of Privacy Practices is posted and on the East Louisville Pediatrics PSC website (eastlouisvillepediatrics.com). This Notice of Privacy Practices also describes the patient's rights and the duties of East Louisville Pediatrics, PSC with respect to protected health information.

East Louisville Pediatrics, PSC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a reviewed notice of privacy practices by accessing the East Louisville Pediatrics, PSC web site, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of the patient's next appointment.

Patients eighteen (18) years old and over must sign below. Parent, Guardian or Personal Representative must sign for minors (under 18 years of age).

_____Signature of Patient, Parent, Guardian or Personal Representative

_____Print name of Patient, Parent, Guardian or Personal Representative

_____Description of Personal Representative's Authority. New patients personal representatives may be required to present appropriate documentation as to authority.

Please print name of patient and any other minor children for which this consent applies

Please list other personal representatives authorized to receive PHI (Personal Health Information) for the above purposes. Add additional pages as needed. Note: **PHI will not be released to anyone not listed below unless required by law.**

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