Consent for the Use or Disclosure of Protected Health Information (HIPAA)
Children's Heart Specialists, P.S.C.

As required by the Health Insurance Portability and Accountability Act of 1996 this practice may not use your personal health information for the purpose of treatment, payment or health care operations unless authorized by you. You have the right to review our Notice of Information Practices prior to signing this consent form. You may request restrictions on the uses and disclosures described in the notice of information practices by describing the requested restrictions in the "restriction request" section of this form.

CONSENT SECTION Patient's Name_____

I, _____(print name), legal custodian, hereby consent to the use and disclosure of my (child's) personal health information for the purposes of treatment, payment and health care operations including letters, test results, and communications with the primary physician and other consultants. My signature below indicates that I have been given an opportunity to read the Notice of Information Practices and to have any questions answered before signing. I understand that I may request restrictions on the uses and disclosures of my (or my child's) health information at any time by completing and signing the restriction request. I understand that I may revoke this consent at any time by signing the revocation section of my copy of this form and returning it to the practice. I further understand that any such a revocation does not apply to the extent and persons authorized to use or disclose my health information. I may be called for appointment reminders and laboratory or CV test results and CHS may leave a message in my voice mail or answering machine.

X_____ _____

Signature Date

RESTRICTION REQUEST SECTION (Optional)

I hereby request the following restrictions on the uses and disclosures of health information:

_____

_____

_____ _____

Signature Date

Reviewer Section (To be filled out by CHS staff)

The terms of this request **are**/**are not** (circle one) acceptable.

_____ _____

Signature Date

Privacy/Security Committee Member:

Print Name_____ Title_____

_____

REVOCATION SECTION (DO NOT sign unless you want to cancel this consent)

I hereby revoke this consent.

_____ Date _____

For detailed information, please click on: Notice of Information Policy Practices & Privacy Policy