Nesbit & Forrester
PEDIATRICS

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

By signing below, you hereby consent for this practice to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations.

You should read the Notice of Privacy Practices for Protected Health Information attached to this form before signing the consent. The terms of this notice may change from time to time, and you may always get a revised copy of it by asking the Privacy Officer.

You have the right to request that this practice restrict how Protected Health Information is used or disclosed to carry out treatment, payment or health care operations. This practice is not required to agree to requested restrictions; however; if this practice agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

You may communicate with the following individuals regarding my condition or course of treatment:	You may communicate confidential information to me, including my invoices for services to the following address and/or phone number:	You may NOT communicate with the following individuals regarding my condition or course of treatment or communicate confidential information to:
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	
______________________		

As the legal guardian, I have authority to act for the individual because I am the individual's ____________.
(relationship)

Signature:	Date:

Patient Name ______________________________ DOB ____________________