Willow Bend Pediatrics

Acknowledgement of Receipt of Notice of Privacy Practices and Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Willow Bend Pediatrics or disclosed to others as outlined in the Notice of Privacy Practices. Please review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information. Willow Bend Pediatrics may or may not agree to restrict the use or disclosure of your protected health information. If Willow Bend Pediatrics agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Signature

By my signature below I acknowledge that I have reviewed Willow Bend Pediatrics' Notice of Privacy Practices and this consent form and give my permission to Willow Bend Pediatrics to use and disclose my health information in accordance with these documents. I understand that I may ask questions about the Notice of Privacy Practices and/or request a copy of the notice at any time.

____ ______ ______/______/______

Name of Patient (Please Print) Date of birth Date

____ ______________________________

Signature of Patient or Personal Representative Relation of Personal Representative