Gold Coast Pediatrics

Consent to Treat and Discuss with Family Members

I consent to the use of disclosure of my protected health information by my provider for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the provider. I understand that diagnosis or treatment of me by my provider may be conditioned upon my consent as evidenced by my signature below

I have received and have the right to review the Notice of Privacy Practices prior to signing this consent. By signing this form, I am consenting to Gold Coast Pediatrics use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. My provider is not required to agree to the restrictions that I may request. However, if my provider agrees to a restriction that I request, the restriction is binding. The provider has taken action in reliance on this Consent

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

The provider reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of my provider and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment

The provider may provide information to other doctors involved in my care. Also, if listed, she may release information to the following family members;

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Printed Name of Parent or Legal Guardian Signature of Parent or Legal Guardian

_____
Printed Name of Patient

DATE:_____

18 Railroad Ave, Glen Head, New York, 11545