



CATHERINE L. WOOD, M.D.
SUSAN A. BRANNON, M.D.
CHERYL A. OUTLAND, M.D., M.P.H.
LAMENDA N. BLAKENEY, M.D.
ELIZABETH W. DIEBEL, M.D.
RAMA L. MUKKAMALA, M.D.

Partners in Pediatrics, LLC • 8160 Seaton Place • Montgomery, Alabama 36116 • (334) 272-1799 • Fax: (334) 272-4876

Consent for the Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Partners in Pediatrics, LLC or disclosed to others for the purposes of treatment, obtaining payment or supporting the day to day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use and Disclosure of Your Information

You may request a restriction on the use and disclosure of your protected health information.

Partners in Pediatrics, LLC may or may not agree to restrict the use and disclosure of your protected health information. If Partners in Pediatrics, LLC agrees to your request, the restriction will be binding on the practice. Use and disclosure of protected health 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 and disclosure that has already occurred prior to the date on which your revocation of your consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Partners in Pediatrics, LLC reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this consent form and give my permission to Partners in Pediatrics, LLC for the use and disclosure of my health information in accordance with this consent.

Patient Name: _____

Signature (Parent or Guardian): _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____