HIPAA CONSENT
ROCKDALE PEDIATRICS HEALTHCARE P.C
2020 HONEY CREEK PARKWAY SE CONYERS GA 30013
PHONE:770-922-0553

PARENT/PATIENT/GUARDIAN CONSENT FORM :The Department of Health and Human Services has established a Privacy Rule to help insure that personal health care information is protected for privacy. The Privacy Rule was also created to provide a standard for health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations. As the parent or guardian of our patient, we want you to know that we respect the privacy of your child personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel need your child health care information and information about treatment, payment, or health care operations, to provide health care that is in your child best interest. We also want you to know that we support your full access to your child personal medical records. We may have indirect treatment relationships with your child (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent to the use or disclosure of your child personal health information, but this must be in writing. Under the law, we have the right to refuse to treat your child should you choose to refuse to disclose your child Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your child PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions, and revoke consent in writing after you have reviewed our privacy notice.

PATIENT NAME ____

PATIENT DATE OF BIRTH_____________________

PARENT/GUARDIAN NAME: ____________________________

PATIENT/PARENT/GUARDIAN SIGNATURE: ______________________

TODAY'S DATE: __________________________