

Kaplan Pediatrics and Associates

PATIENT CONSENT FORM

I understand that as part of my healthcare, Aaron Kaplan, D. O. and Jennifer Kriska, PNP. originates and maintains health records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information is utilized to plan my child’s care and treatment, to bill for services provided to my child, to communicate with other healthcare providers and other routine healthcare operations, such as assessing quality and reviewing competence of healthcare professionals.

The PHYSICIAN’S *Notice of Privacy Practices* provides specific information and complete description of how my child’s personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this consent. I understand that the PHYSICIAN reserves the right to change the *Notice of Privacy Practices*. Prior to implementation of the revised *Notice of Privacy Practices*, the revised *Notice* will be mailed to me if I provide my address below. I understand that I have the right to restrict the use and/or disclosure of my child’s personal health information for treatment, payment, or healthcare operations and that the PHYSICIAN is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that the PHYSICIAN has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

- I request the following restrictions on the use and/or disclosure of my child’s personal health information.

I further understand that any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and have reviewed the PHYSICIAN’S *Notice of Privacy Practices* .

Signature of Patient’s Legal Representative

Date

Print Name of Patient

Print Name of Legal Representative

Fill in address if you would like changes to the *Notice of Privacy Practices* sent to you:
