Lowcountry Pediatrics, PA

CONSENT

To the Use and Disclosure of Health Information
For Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare Lowcountry Pediatrics, PA originates and maintains health records describing my health history, symptoms, examinations, test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among any health professionals who contribute to my care
- A source of information for applying my diagnosis and service information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been given the opportunity to read the Notice of Privacy Practices describing the way my information may be used and disclosed by this practice. I understand that I have the right to discuss the notice prior to signing this consent. I understand that this practice reserves the right to change their notice and will provide me with a copy of the revised notice at my request. I am aware that I have the right to see and obtain copies of my medical record and that I may have to pay a reasonable charge for any copies made. I understand that a history of all disclosures will be made accessible to me within 60 days of my request. I also have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that this practice is not required to agree to the restrictions I request. I understand that I may revoke this consent at any time, in writing, except to the extent that this practice has already taken action in reliance thereon.

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Patient's Name (minor) Please Print Date

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Signature of Parent/Legal Representative Relationship to Patient