ALPHA PEDIATRICS,PA

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HIPPA FORM

Be sure to download and save this document to your computer. This form can be filled out on your computer and emailed to alphapedi01@gmail.com or print the form out and bring it to the office filled out. Thank You!

HIPPA FORM:

Use and Disclosure of Protected Health Information:

I understand my protected health information will be used by **Alpha Pediatrics, P.A.** or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day to day health care options of the practice.

Notice of Privacy Practices:

I have reviewed and understand the Notice of Privacy Practices, I understand my rights as to my protected health information, and how this information will be used, disclosed and protected.

Requesting a Restriction on the Use or Disclosure of my Protected Information:

I understand that I can, at anytime, request a restriction on the use or disclosure of my protected health information. I further understand that **Alpha Pediatrics, P.A.** may or may not agree to restrict the use or disclosure of my protected health information.

If **Alpha Pediatrics, P.A.** agrees to my request, I understand that the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

Revocation of Consent:

I understand that I may revoke this consent to the use and disclosure of protected information. To do so, I must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which my revocation of consent is received will not be affected.

Reservation of the Right to Change Privacy Practices:

Alpha Pediatrics, P.A. reserves the right to modify the privacy practices outline in the notice.

Signature:

I have reviewed this consent form and give my permission to **Alpha Pediatrics, P.A.** to use and disclose my health information with it.

Signature _____ Date _____

Patient Name *(Print)* _____ Date _____

Signature of Parent or Guardian _____ Date _____

Name of Parent or Guardian *(Print)* _____ Date _____