Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I,_____ (Parent or Guardian), understand that as part of my health care, James Brian Thornburg D.O., P.A. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, 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 the many health professional who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more completed description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment payment or health care operations.
    - The right to know that third party funded marketing for products and services can no longer be directed to patients without their prior written authorization.
    - The right to limit disclosures related to services that the patient pays for in full.
    - The right to be notified of any privacy breaches.
    - The right to request a copy of your medical records (electronic or paper).

I understand that James Brian Thornburg D.O., P.A. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon, I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that James Brian Thornburg DO., P.A. reserves the right to change the notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should James Brian Thornburg D.O., P.A. change the notice, they will send copy of any revised notice to the address I've provided, (whether U.S mail or if I agree email).

I wish to have the following restrictions to use or disclosure of my health information:

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept the terms of this consent

Patient/Parent/Guardian Signature: _____

Date of consent: _____

- **Changes to HIPAA regulations 2013**

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law.
You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to treatment for disease, injury or well care at Thornburg Pediatrics for you or your child. The information collected during this treatment is protected health information and you further consent to the use and disclosure of protected health information about you or your child for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 and 2013.

The patient understands that:

- The patient/parent consents to treatment for injury, disease or well care.
- Protected health information may be disclosed or used for treatment, payment, or health care operations with the exception of services paid in full;
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice;
- The Practice reserves the right to change the Notice of Privacy Practices;
- The patient has the right to restrict the uses of their information.
- The patient/parent may revoke this Consent in writing at any time and all future disclosures will then cease;
- The Practice may condition receipt of treatment upon the execution of this Consent.
- The Patient/Parent has the right to request one copy of their medical records (electronic or paper) free of charge. All other requests are billed at $1.00 per page.

This Consent was signed by: _____
Signature: _____
Relationship to Patient (if other than patient): _____
Patient's name: _____
Date: _____