Haymarket Pediatrics PLC

HIPAA
Health Insurance Portability and Accountability Act

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH CARE INFORMATION AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

As the parent, patient or legal guardian, I hereby give consent for Haymarket Pediatrics PLC to use and disclose protected health information about me or my child/children to carry out treatment, payment, and healthcare operations. I have the right to review the Notice of Privacy Practices and I have been given the opportunity to review that document prior to signing this consent. I am also aware that I have the right to request a written copy of the office's Notice of Privacy Practices and that Haymarket Pediatrics PLC reserves the right to revise its Notice of Privacy Practices at any time. There is no expiration date for this consent.

Name of Child/Children:

1._____ **4.**_____

2._____ **5.**_____

3._____ **6.**_____

Parent, Patient or Legal Guardian:

Print Name: _____

Relationship: _____

Signature: _____ **Date:** _____