



ACKNOWLEDGEMENT:

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practices provided to me by a representative of the Practice of Middletown Pediatrics.

Patient's Name (Please Print)

Signature of Patient or Patient's Representative & Relationship to Patient Date

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION

I authorize Middletown Pediatrics to use and disclose my healthcare information for the purposes of Treatment, Payment and Health Care Operations.

- ◆ Treatment includes activities performed by a health care provider, assistant, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any health care Provider who covers our Practice by telephone or sees patients on our behalf.
- ◆ Payment includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.
- ◆ Health Care Operations includes the necessary administrative and business functions of our office.

I further authorize Middletown Pediatrics to use and disclose the following specific health and medical information for the below listed purposes

Specific medical/health information consisting of:

For the specific purpose of:

I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that Middletown Pediatrics has already used or disclosed the information in reliance on this Consent.

Patient's Name (Please Print)

Signature of Patient or Patient's Representative & Relationship to Patient Date