CONSENT TO USE & DISCLOSE HEALTH INFORMATION (2017)

Abilities Therapy Network

This office is required by Federal Regulations to inform our Patients in regards to the use of your child's health information in accordance to Health Insurance Portability & Accountability Act of 1996 or HIPAA.

I understand that as part of my child's health care, Abilities Therapy Network originates and maintains paper and/or electronic records describing my child's health history, symptoms, examination and test results, diagnoses, treatments, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my child's care and treatment
- A means of communication among health professionals who contribute to my child's care
- A source of information for applying my child's diagnosis and treatment information to my bill
- A means by which a third-party can verify the services billed to me actually took place

I understand and have been provided access to a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. This notice is located in the waiting area in plain view. I understand that I have the following rights and privileges:

- The right to review the *Notice of Privacy Practices* prior to signing this consent, allowing treatment, or making payment for services rendered and the right to a paper copy of the *Notice of Privacy Practices*
- The right to object to the use of my child's health information for directory purposes
- The right to request special privacy protections
- The right to request confidential communications
- The right to inspect and copy
- The right to amend or supplement
- The right to an accounting of disclosures

I understand that Abilities Therapy Network 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 may refuse to treat my child as permitted by Federal Regulations.
I understand that Abilities Therapy Network reserve the right to change their *Notice of Privacy Practices.* I further understand that Abilities Therapy Network uses a computerized state vaccine registry to track immunization requirements and maintain immunization records. We will enroll your child unless you inform us in writing that you do not wish to participate.

Please note that I consent to the following uses of my child's medical information (Initial Below):

_____ I allow my child's medical information to be released to: _____

_____ Other: _____

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. I hereby consent to such disclosure for these permitted uses. I also hereby consent to such disclosures via fax and email.

I fully understand and accept the terms of this consent.

_____ _____

Parent or Legal Guardian Signature **Date**

Child's name and Date of Birth

REVOKE CONSENT
(do not sign below unless you are revoking the above consent)

I hereby revoke the above consent effective immediately. I understand that revoking this consent means that my medical information and protected health information will no longer be discussed or disclosed (released) to the above individuals and that a new consent will need to be completed if this changes.

_____ _____

Signature of Parent or Legal Guardian Date signed