



Consent for Purposes of Treatment, Payment and Healthcare Operations

Patient Name: _____ Chart#: _____

I consent to the use or disclosure of my protected health information by Bakersfield Pediatrics, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the medical practice. I understand that diagnosis or treatment of me by Bakersfield Pediatrics may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the medical practice. Bakersfield Pediatrics is not required to agree to the restrictions that I may request. However, if the medical practice agrees to a restriction that I request, the restriction is binding on Bakersfield Pediatrics and its employees.

I have the right to revoke this consent, in writing, at any time, except to the extent that Bakersfield Pediatrics has taken action in reliance on this consent. Otherwise, this consent is good for a period not to exceed 6 years from date signed.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Bakersfield Pediatrics' Notice of Privacy Practices prior to signing this document. The medical practice's Notice of Privacy Practices will be provided to me to review, if requested. The Notice of Privacy Practices describes in more detail the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Bakersfield Pediatrics. The Notice of Privacy Practices for Bakersfield Pediatrics is also posted in the medical office waiting area. The Notice of Privacy Practices also describes my rights and Bakersfield Pediatrics duties with respect to my protected health information. Bakersfield Pediatrics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices that are described in the Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment. **Any questions regarding this document of the Notice of Privacy Practices should be directed to our office (661) 663-4700.**

Signature of Patient or Personal Representative

Office Representative Signature

Print Name of Patient or Personal Representative

____ Restrictions Requested

Date _____

____ No Restrictions

Description of Personal Representative's Authority