Pediatric Associates of Julington Creek

CONSENT FOR PURPOSES OF TREATMENT, AND HEALTH CARE OPTION

I, _________________________________, consent to the use of disclosure of my child's protected health information by Pediatric Associates of Julington Creek for the purpose of diagnosing or providing treatment to him/her, obtaining payment for his/her health care bills to conduct health care operations of Pediatric Associates of Julington Creek

I understand that diagnosis or treatment of my child by Pediatric Associates of Julington Creek may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request restrictions to how my child's protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. Pediatric Associates of Julington Creek is not required to agree to restrictions that I may request. However, if PAJC agrees to restrictions that I request, the restriction is binding on PAJC.

My child's "protected health information" means health information, including his/her demographic information, collected from me and created or received by his/her physician, another health care provider, a past, present, or future physical or mental health or condition and identify him/her.

I understand I have the right to review Pediatric Associates of Julington Creek's Notice of Privacy Practices prior to signing this document.

The Pediatric Associates of Julington Creek Notice of Privacy has been provided for me.

The Notice of Privacy Practices for Pediatric Associates of Julington Creek is also provided at
1631 Racetrack Rd. Suite 101 Jacksonville Florida 32259.

This Notice of Privacy Practices for Pediatric also describes my child's rights and the duties of Pediatric Associates of Julington Creek with the respect to my child have protected health information.

Pediatric Associates of Julington Creek 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, by calling the office and requesting the revised copy be sent in the mail or asking for one at my next appointment.

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Printed Patient Name: ____

Printed Parent Name: ____

Relationship to Patient: ____

Signature: ____ **Date:** ______________________