SOMERSET PEDIATRIC GROUP
CONSENT TO USE & DISCLOSE HEALTH INFORMATION

For Patients 18 Years and Older

In compliance with the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)****, we are required to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to your health information.***

PLEASE READ THE FOLLOWING CAREFULLY!

I understand that as part of my health care, Somerset Pediatric Group originates and maintains electronic records describing my health history, symptoms, examination, test results, diagnoses, treatments, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among health professionals who contribute to my care
- A source of information for applying my 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.

I understand that Somerset Pediatric Group 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 me as permitted by Federal Regulations. I understand that Somerset Pediatric Group reserves the right to change their ***Notice of Privacy Practices***.

Please note that I consent to the following uses of my medical information, (Initial Below)

I allow those named below to have complete access to my medical records.

(Name)_____ Relationship to Patient_____

(Name)_____ Relationship to Patient_____

I understand that as part of this organization's treatment, payment or healthcare operations, I allow my parent(s), legal guardian or the guarantor on my account (financial provider) access to my diagnosis and treatment information *as it applies to any charges I incur at Somerset Pediatric Group.* If access is denied, SPG cannot bill your visit to your guarantor's insurance and we will require **payment in full at time of service**.

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.

I fully understand and accept the terms of this consent.

_____ _____
Patient Name Date

_____ _____
Patient Signature Date of Birth

Patient Cell Phone #_____

Patient Email Address_____