SOMERSET PEDIATRIC GROUP
CONSENT TO USE & DISCLOSE HEALTH INFORMATION

For Patients 18 Years and Older

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.

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 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 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 my parents complete access to my medical records.

_____I allow my parents 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 parents' insurance and we will require payment in full at time of service.

_____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.

I fully understand and accept the terms of this consent.

_____ _____
Print Name Date

Cell #_____ _____
Date of Birth

_____
Signature