HIPPA PRIVACY- PRACTICES FOR PROTECTED HEALTH INFORMATION

I, _____(patient/ parent/legal guardian), understand that as part of my health care, Carolina Child Neurology, PLLC originates and maintains paper and/or electronic records, describing my health history, symptoms, examination and test results, diagnosis, treatment 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 surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals.

I understand that I have the following rights and privileges:

- The right to review the Notice of Privacy Practices (45 CFR 164.520) prior to signing this consent
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that Carolina Child Neurology, PLLC 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 has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section164.520 of the Code of Federal Regulations.

I further understand that Carolina Child Neurology, PLLCreserves the right to change their notice and practices and prior implementation, in accordance with Section164.520 of the Code of Federal Regulations. Should Carolina Child Neurology, PLLC change their notice, they will post the revised copy in the reception area at the office and provide a copy to me at my request. I understand and agree that Carolina Child Neurology, PLLC may contact me at my home or work number provided concerning appointments and other relevant medical information.

I wish to have the following restrictions added to the use or disclosure of my health information and/or alternate communications:

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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 and I consent to such disclosure for these permitted uses, including disclosures via electronics, fax, telephone or mail.

- I fully understand and accept the terms of this consent
- I fully understand and decline the terms of this consent

Patient/ Parent/Legal Guardian Signature

_____Date:_____