Sunshine Pediatrics of Ocala, P.A.
1900 SW 20th Place, Ocala, FL 34471
352.840.5437

PATIENT CONSENT FOR USE, DISCLOUSURE OR REQUEST OF HEALTH INFORMATION AND TREATMENT OR PAYMENT

Patient Name: _____

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your child's health history, symptoms, examinations, test results, diagnoses, treatment, and any plans for future care or treatment. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals who contribute to your healthcare
- Submit your diagnosis and treatment information for payment from insurance companies or others

"ONLY AS PERMITTED BY STATE OR FEDERAL LAW", you are giving this practice CONSENT to do the following:

- **To disclose, as may be necessary, your health information (including HIV status, drug/alcohol abuse and psychiatric notes) to other healthcare providers (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) for your treatment and/or healthcare.**
- **To request from other healthcare entities (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.**
- **To submit diagnoses and treatment information to insurance company(s), other agencies and/or individual(s) for payment of our services.**
- **Leave appointment reminders or information we believe necessary for your treatment or payment (please check one, both or neither: on an answering machine/voicemail ( ) or with a member of your household ( ). The information will be the minimum necessary in our professional judgment.**
- **Discuss your health information (only as necessary in our judgment) with family members or other person who are or may be involved with your healthcare treatment or payments. Please list below name AND relationship of person(s) with whom we may share your healthcare or payment information:**
  _____
  _____

You may request a copy of our **"Notice of Patient Privacy Practices"** that provides a more complete description of health information uses and disclosures as required by the HIPAA standard. You also have the right to the "**Patient Health Information Privacy Practices"** prior to signing this consent.

I fully understand and agree to this consent and acknowledge the above rights and disclosures.

Signature Printed Name Date

*If other than patient is signing, are you the parents, legal guardian, legal custodian or have Power of Attorney for treatment and/or payment for this patient. Yes ( ) No ( ) RELATIONSHIP_____.
If you are not the parents, **please provide a copy of your legal authority** for this patient.

FOR OFFICE USE ONLY:
( ) Patient/Parent refused to sign this consent form. Reason for refusal to sign: _____