SG PEDIATRICS OF LAKE ORION
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Consent to Use and Disclose Protected Health Information

Use and disclosure of Your Child's Protected Health Information
Your child's protected health information will be used by *SG Pediatrics of Lake Orion* or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices
SG Pediatrics of Lake Orion is required to provide you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Policies and Practices" brochure provided to you. **PLEASE REVIEW IT CAREFULLY.**

Requesting a Restriction on the Use or Disclosure of Your child's Information
You may request a restriction on the use or disclosure of your protected health information. *SG Pediatrics of Lake Orion* may or may not agree to restrict the use or disclosure of your protected health information (see authorization).

If *SG Pediatrics of Lake Orion* agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected health information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices
SG Pediatrics of Lake Orion reserves the right to modify the privacy practices outlined in the notice. I understand that *SG Pediatrics* will notify me of these changes via the method I have authorized or upon my next appointment.

Signature
I have reviewed this consent form, received the brochure entitled "Notice of Privacy Policies and Practices" and give my permission to *SG Pediatrics of Lake Orion* to use and disclose my child's health information in accordance with this consent and the notice provided.

____________________________________ ____________________________________
Name of Patient (PRINT) **Signature of Patient** **Date**

____________________________________ ____________________________________
Signature of Patient Parent/Guardian **Relationship to Patient** **Date**

Authorization of Use and Disclosure of Protected health Information

Appointment Reminders: The practice may use your child's information to remind you about upcoming appointments. How would you like to be contacted regarding appointments, treatment, and/or other information pertinent to your healthcare and/or payment for your child's healthcare provided at *SG Pediatrics*? (Please check all that apply.)

Home Phone ________ Cell Phone _______ Work Phone__________ Other __________

If you have an answering machine or voicemail, may we leave a message regarding appointments, treatment, and/or other information pertinent to your healthcare and/or payment for your child's healthcare provided at *SG Pediatrics*? **YES______ NO ______**

If "NO" how else may we contact you regarding this information? ___________________
Please list any other restrictions regarding messages or reminders about your child's healthcare:

Other Uses and Disclosures: Disclosure of our child's health information or its use for any purpose other than those listed in the "Notice of Privacy Policies and Practices" brochure and/or consent, requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your child's information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified of us of your decision. You have the right to request restrictions on use and disclosure of your child's information.

I would like the following restrictions regarding the use and disclosure of my child's health information: ____

Persons Authorized to Receive Information:
Health information *SG Pediatrics* collects or receives about you may be disclosed to the following persons. **This includes authorization to bring a child to any appointment and make all the medical decisions for that child at that appointment:**

____________________________________	____________________________________
Name of person/relationship	**Name of person/relationship**
____________________________________	____________________________________
Name of person/relationship	**Name of person/relationship**

I authorize the person(s) listed above to receive all health information about appointments, treatment, and/or other information pertinent to my child's healthcare and/or payment for my child's healthcare provided at *SG Pediatrics*. YES _____ NO _____
I ***do not*** authorize the following information to be disclosed to any other parties except to me as the patient's parent/guarding. (Please specify): ______________________________________
(Legal documentation must be provided if excluding either parent)

I authorize SG Pediatrics to release the following information to my child's school or daycare:
Immunization record**: YES ___ NO ____** Physical Examination: **YES ___ NO ___**

Name of School/Daycare: _____________________________________ Phone ____________