Medical Pediatrics, Ltd.

1700 West Central Road, Suite 200
Arlington Heights, IL 60005
847-392-1880

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I, _____, hereby give my consent to Medical Pediatrics, Ltd. to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of _____.

(Patients' Name - List all children in family seen in our office)

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available via paper copy.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signed: _____

Date: _____

If you are not the patient, please specify your **relationship to the patient** _____.

– Patient's file