## Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

I have been provided and review the Physician's Notice of Privacy Practices.

I request the following restrictions on the use and/or disclosure of my Personal Health Information:

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I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior authorization, except as otherwise provided by law.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. Such revocation, however, shall not affect any disclosures we have already made in reliance to your prior Consent. This Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____
Patient's Name Social Security Number

_____ _____
Signature of Parent/Guardian Date

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