CONSENT TO TREAT

I consent to the use or disclosure of my child's protected health information by Palm Beach Pediatrics, P.A. for the purpose of diagnosing and providing treatment, obtaining payment for health care bills or to conduct health care operations of Palm Beach Pediatrics, P.A. I understand that diagnosis or treatment of my child by Palm Beach Pediatrics, P.A. may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my child's protected health information is used or disclosed to carry out treatment, payment or healthcare operation of the practice. Palm Beach Pediatrics, P.A. is not required to agree to the restrictions that I may request. However, if Palm Beach Pediatrics, P.A. agrees to a restriction that I request, the restriction is binding on Palm Beach Pediatrics, P.A. and the physicians/providers.

I have the right to revoke this consent, in writing, at any time, except that Palm Beach Pediatrics, P.A. has taken action in reliance on this consent.

My child's "protected health information" means health information, including my child's demographic information, collected from me and created or received by my physician/provider, another healthcare provider, a health plan, my employer or health care clearinghouse. This protected health information related to my child's past, present or future physical or mental health condition and identifies my child, or there is a reasonable bases to believe the information may identify my child.

I understand I have a right to review Palm Beach Pediatrics, P.A.'s Notice of Privacy Practices prior to signing this document. The Palm Beach Pediatrics, P.A.'s Notice of Privacy Practice has been provided to me. This Notice of Privacy Practice describes the types of uses and disclosures of my child's protected health information that will occur in my child's treatment, payment of my child's bills or in the performance of health care operation of Palm Beach Pediatrics, P.A. The Notice of Privacy Practice for Palm Beach Pediatrics, P.A. is also provided in the patient's waiting room. This Notice of Privacy Practice also describes my right and the Palm Beach Pediatrics, P.A.'s duties with respect to my protected health information.

I also authorize Palm Beach Pediatrics, P.A. to leave reminders for appointments and messages to call the office on my home answering machine or cell phone.

Palm Beach Pediatrics, P.A. reserves the right to change the privacy practices that are described in the Notice of Privacy Practice. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent via electronic mail or asking for one at the time of my child's next appointment.

If I do not sign this consent, Palm Beach Pediatrics, P.A. may decline to provide treatment to my child.

PARENT / PERSONAL REP. NAME (PLEASE PRINT) _____ PARENT / PERSONAL REP. SIGNATURE _____ DATE _____

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY _____

CHILD'S NAME _____ DATE OF BIRTH _____

IF REFUSED, FOR WHAT REASON (WITH SIGNATURE OF EMPLOYEE, TIME, DATE, and COSIGNED BY MANAGER ON SITE) _____

DATE _____ EMPLOYEE SIGNATURE _____ MANAGER'S SIGNATURE _____