EL PASO PEDIATRIC ASSOCIATES, P.A.

HIPPA CONSENT FORM

I understand that as part of the provisions of healthcare services, EL PASO PEDIATRIC ASSOCIATES, PA. creates and maintains health records and other information describing, among other things, my health and medical history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided (or will be provided on my first visit) with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the Notice of Privacy Practices prior to signing this Consent Form. I understand that EL PASO PEDIATRIC ASSOCIATES, P.A. reserves the right to change its Notice and practices with regard to the use and disclosure of health information. I understand that I have the right to request restrictions as to how my health information may be used or disclosed for treatment, payment, or healthcare operations, but that EL PASO PEDIATRIC ASSOCIATES, P.A. is not required to agree to the requested restrictions.

By signing this Consent Form, I acknowledge I have been provided (or will be provided on my first visit) a copy of the Notice of Privacy Practices, and consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and healthcare operations. I have the right to revoke this consent in writing. However, I understand that revocation will not affect disclosures made prior to the revocation, and may not affect disclosures reasonably necessary for treatment, payment or healthcare operations.

This consent is valid until revoked by me in writing. A photocopy or facsimile of this consent is as valid as the original.

Name (Printed) _____ Date _____

Signature (Guardian if patient is a minor) _____ Social Security Number _____