

## Consent Agreement

I, \_\_\_\_\_, parent or legal guardian of \_\_\_\_\_, understand that as part of my child's healthcare, The Pediatric Center, Inc. originates and maintain health records describing my child's health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care of treatment. I understand that this information serves as:

- A basis for planning my child's care and treatment
- A mean of communication among the many health professionals who contribute to my child's care
- A source of information for applying my child's diagnosis and procedural information to the bill
- A mean by which a third party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that The Pediatric Center, Inc. reserves the right to change their notice and practices and will provide a copy to me and my child's first visit after the revision. I understand that I have the right to request restrictions as to how my child's health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that The Pediatric Center, Inc. had already taken action in the reliance thereon.

I wish to have the following restrictions to the use or disclosure of my health information.

I fully understand and accept / decline (circle one) the terms of this consent.

\_\_\_\_\_  
(Parent or Legal Guardian)

For

\_\_\_\_\_  
(Child' Name)

\_\_\_\_\_  
Date