CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

By signing below, you hereby consent for this Practice to use or disclose information about you and/or child(ren), (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose of treatment, payment and health care operations. You may refuse to sign this consent form. You should read the Noticed of Privacy Practices for PHI attached to this form before signing the consent. You acknowledge that the Notice of Privacy Practices and the Notice of Individual Rights have been reviewed and made available to you. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Privacy Officer for this practice. You have the right to request that the practice restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. The practice is not required to agree to requested restrictions, however; if the practice agrees to your requested restrictions, the restriction is binding on it. Information about you and/or child(ren) is protected under federal law, and you have the right to revoke this consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to this consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.
Due to patient confidentiality, please list below if you wish to allow any family members or any person that we may communicate with the following individuals regarding appointments, medical information, course of treatment, or invoices of payment about the patient.
Please Print:

NAME:_____ **RELATIONSHIP:**_____ **TELEPHONE:**_____

NAME:_____ **RELATIONSHIP:**_____ **TELEPHONE:**_____

NAME:_____ **RELATIONSHIP:**_____ **TELEPHONE:**_____

I understand that this will remain in effect until I give written notice to Jydes Family Clinic to remove any of the persons listed above.

PRINT: CHILD'S/PARENT NAME (ONE CONSENT FORM PER CHILD) D.O.B

PARENT/GUARDIAN/PATIENT SIGNATURE DATE

As a personal representative, I have authority to act for the individual because I am:
PLEASE CIRCLE ONE:
MOTHER / FATHER / GUARDIAN / OTHER: _____

N/A