QUAKERBRIDGE PEDIATRICS

Quakerbridge Pediatrics, PC
Milan R. Kapadia, M.D.; F.A.A.P.
Ankita K. Modh, PA-C

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent to Quakerbridge Pediatric to use and disclose protected health information about me to carry out treatment, payment, and health care operations.

With this consent, Quakerbridge Pediatrics may call my home or other alternative location and leave a message on voice mail or answering machine for the treatment, payment and health care operations. For example: Appointment reminders, child's clinical care, a message to call our office to obtain laboratory results or other study results.

With this consent, Quakerbridge Pediatrics may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment or health care operation, such as appointment reminder cards and patient statements.

I have the right to request that Quakerbridge Pediatrics restrict how it uses or discloses my protected health care operations to carry out treatment, payment and health care operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Quakerbridge Pediatrics use and disclosure of my Protected Health Information to carry out treatment, payment and health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Quakerbridge Pediatric may decline to provide treatment to my child.

I have received a copy of the Notice of Privacy Practices from Quakerbridge Pediatrics.

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Patient's Name

_____ _____

Signature of Patient or Legal Guardian **Date**

_____ _____

Print Name of Patient or Legal Guardian **Your Relationship to Patient**