MANCHESTER PEDIATRIC MEDICAL DAYCARE

Consent to Use and Disclosure of Health Information for
Treatment, Payment of Healthcare Operations

Patient: ____Date of Birth: _______________

I understand that the center maintains, uses and discloses my personal health information in order to provide for my care and treatment, to arrange for billing and payment for my care and carry out general management and operations of the facility such as quality review.

I understand that these and other uses and disclosures of my personal health information are described more completely in the center's "Notice of Privacy Practices."

I understand that the center reserves the right to change its privacy practices described in the Notice of Privacy Practices and to make the new Notice provisions effective for all protected health information already received and maintained by the facility as well as for new information. I understand that prior to implementation, the center will mail a copy of the revised Notice of Privacy Practices to the address I have provided. In addition, I understand that I have the following rights:

- The right to receive and review the center's Notice of Privacy practices before signing this consent.
- The right to request restriction on how protected health information about me is used or disclosed for treatment, payment or health care operations. The center is not required to agree to my request, but if it does, it will be bound by its agreement.
- The right to revoke this Consent, in writing, except to the extent the center has acted in reliance on the Consent.
- The right to receive a copy of this Consent form.

I consent to the use and disclosure by the Center and its agent or representatives of all my personal health information for purposes of treatment, payment and health care operations.

By signing below, I acknowledge that I have read and understand this Consent form. I acknowledge that I have reviewed or was offered the opportunity to review the Privacy Notice prior to signing this form.

_______________________________________ ____________________

Signature of Patient or Patient's Representative Date

If signed by the Patient's Representative, please print name and describe relationship to patient

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Printed Name Date