915 Gessner, Suite 985
Houston, TX 77024
Office: (713) 461-9100
Fax 713-461-0176

HIPPA PATIENT CONSENT FORM

The Health Insurance Portability and Accountability Act of 1995 (HIPPA) requires medical practices to establish policies to protect the privacy of patient health information and inform patients how their personal information will be used or disclosed. Our complete Notice of Privacy Practices is available at the reception desk and may be reviewed by a patient or parent at any time. Take home copies of the policy care are available upon request.

By signing this form, you consent to the use and disclosure of protected health information about you or your children for treatment, payment and health care operations. This includes disclosing protected health care information to other physicians participating in your treatment, using minimal protected information necessary to submit claims to your insurance carrier and providing information requested by insurance carriers for performance review or audit of our physician or practice. Also, protected health information may be released to governmental authorities when public health matters or judicial actions legally require it. Any other disclosure of protected health information will require a separate signed authorization from you. A more complete description of the uses of protected health information is included in the Notice of Piracy Practice.

Under HIPAA, you have the right to request our use of protected information for treatment, payment and health care operations be restricted or even denied. However, under the law we do not have to comply with your request. We will attempt to come to some agreement if this situation should arise.

By signing this form, the patient or parent understands the following:

1. Protected health information may be disclosed or used for treatment, payment or healthcare operations.
2. Memorial City Pediatrics has a notice of Privacy Practices and patients or parents may review this Notice at any time.
3. MCP reserves the right to change its Notice of Privacy Practices as circumstances warrant.
4. The parent or patient may request restriction of use of disclosure of protected health information for treatment, payment or health care operations. However, the practice has the right to deny this request.
5. Other use or disclosure of protected health information will requite a separate authorization signed by the patient (parent of a minor child).
6. The patient or parent may revoke this consent at any time; however, treatment may be conditioned upon execution of this consent.

Patients Full Name: _______________________________________

Signature of Patient: ______________________________________

Relationship to patient (if signed by someone other than the patient): ____________

Date: ____________________ Witness: _________________