Evergreen Pediatrics, Inc.
4205 San Felipe Road, Suite 110
San Jose, CA 95135
408-238-8303

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Pursuant to the requirements found in the Health Insurance Portability and Accountability Act of 1996(HIPAA), the following is offered for your information and consent. Please be aware that it is this office's policy to require your reading and signing of this consent prior to the provision of treatment or any other medical services. If you have any questions, please call your member services department located on the back of your health insurance card.

I, _____, currently residing at _____ in (city)_____, in _____County, CA, do hereby consent to the use and disclosure of my individually identifiable health information by **EVERGREEN PEDIATICS INC.** for the purpose of providing treatment, receiving payment from responsible parties for health care services rendered by **EVERGREEN PEDIATRICS INC.,** and/or engaging in health care operations, such as office management, credentialing case management and quality management.

I understand that "Notice of member's Privacy Rights ("NOTICE") describes in more detail the types of uses of disclosures of Protected Health Information involved in treatment, payment or health care operations, and that I have received a copy of this notice prior to signing this consent . I understand that if I choose to not sign this consent, this provider may withhold medical services other than emergency services.

I understand that if I sign this consent, I still have the right to request a restriction on providers use or disclosure of any and/or all personal health information to any/or all locations, entities or persons, I further understand that the provider is not obligated to agree to my request. However, if the provider does agree to my request, the agreement shall become binding.

I understand that I have the right to revoke this consent in writing at any time except, to the extent that the provider has already relied on this consent, and that any revocation will become effective on the date it has been received by the provider and will apply to the uses and disclosures of health information after the date of receipt.

_____ ____/_____/_____

Patient Name Date

_____ _____

Parent/Guardian Name Parent/Guardian Signature