# RINGGOLD PEDIATRIC CLINIC

## Patient Consent for Physician to Use or Disclose Health Care Information for Treatment, Payment and Health Care Operations

Patient's Name: _____ Date of birth: _____/_____/_____

SSN # _____-_____-_____

I understand that my health information is private and confidential. I understand that Dr. Ho works very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that signing this document means that Dr. Ho may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. Failure to sign this consent may result in the physician declining to treat me.

Dr. Ho has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices used to protect their patients' privacy. I understand that I have the right to read the "Notice" before signing this agreement.

Dr. Ho may update this "Notice of Privacy Practices". If I ask, Dr. Ho will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask Dr. Ho to restrict how my personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that Dr. Ho does not have to agree to my request. If Dr. Ho does agree to my request, I understand that Dr. Ho would follow the agreed limits.

I understand that I have the right to cancel this consent in writing, at any time. If I do cancel the consent, I understand that Dr. Ho may have already used or disclosed information about me and canceling this consent would not effect the information already used or disclosed.

I may cancel this consent at any time by writing, signing, and dating a letter to Dr. Ho. If I write a letter, it myst say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment, and health care operations.

I understand if I cancel this consent, Dr. Ho does not have to provide any further health care services to me.

My signature below indicates that I have been given the chance to review a current copy of Dr. Ho's "Notice of Privacy Practices."

_____ _____

Patient or legally authorized individual signature Date:

_____

Relationship to patient if signed by anyone other than patient )parent, legal guardian, personal representative, etc.)