New Horizon Pediatrics, P.C.
1760 Reston Pkwy., Suite 400 Reston, VA 20190
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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/ date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and full disclosures will then cease.
- The practice may condition receipt of treatment upon the execution of this consent.

May we phone you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, Please provide the full legal name of the members authorized:

_____

_____

***This authorization does not authorize your family member to request or pick up medical records without written and signed consent.**

***Esta Autorizacion no le autoriza al miembro de la familia a solicitor o recoger registros medicos. Debe presenter un consentimiento escrito y firmado por los padres o guardian legal.**

Patient(s) Name: _____ DOB: _____

Parent/Legal Guardian: _____ Relationship to the patient: _____
(Print Name)

Signature: _____ Date: _____
(Parent / legal guardian signature if minor)

Witness: _____ Date: _____