WESTSIDE PEDIATRIC CLINIC

ACKNOWLEDGMENT AND CONSENT

I understand that Westside Pediatric Clinic, PC (referred to below as "This Practice") will use and disclose health information about me.

I understand that my health information may include information both created and received by This Practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information. I understand and agree that This Practice may use and disclose my health information to:

- Make decisions about and plan for my care and treatment
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all my health care and
- Perform various office, administrative, and business functions that support my physician's effort to provide me with, arrange, and be reimbursed for quality, cost effective health care.
- Including confirming appointments in advance and leaving that information on voicemail or answer machine

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by employees, staff, and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practices Notice of Privacy Practices in effect will be posted in the waiting/reception area and available on the website at www.westsidepediatrics.com

I understand that I have the right to ask that some or all my health information not to be used or disclosed in a manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices

By Patient: _____ Date: _____

OR

By Patient Representative: _____ Date: _____

Description of Representative's Authority: _____