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Consent for use and disclosure under Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Your signature below represents consent for Pediatrics and Genetics, LLC to use and/or disclose information about yourself (or another person for whom you have authority to sign) that is protected under federal law, for the sole purposes of *treatment, payment, and health care.*

You understand your rights under HIPAA. You may request a copy of your rights and Pediatrics and Genetics, LLC policies in this regard from our web site, or ask for it at our office.

Privacy will be protected based on the Guardian / Guarantor details in the registration form. Any exception to this needs be requested in writing.

____ ____________________________________
Print Name of Individual or Personal Representative Relationship to Patient

____ ____________________________________
Signature of Individual or Personal Representative Date