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Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I, _____, hereby give my consent to
(Name of Patient or Authorized Agent)

1-2-3 Pediatrics (referred to as the "Clinic") to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the record of the following patients:

1. _____ DOB: _____
2. _____ DOB: _____
3. _____ DOB: _____
4. _____ DOB: _____
5. _____ DOB: _____

I acknowledge receipt of the Clinic's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the Clinic may use and disclose my confidential information.

I understand that the Clinic reserves the right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available to me in the Clinic's office or on the web site.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the Clinic. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the practice's office.

Signed: _____ Date: _____.

If you are not the patient, please specify your relationship to the patient

_____.