Chester County Pediatrics

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

I, _____, hereby give my consent to the practice to use or disclose, for
(Name of Patient or Authorized Legal Representative)
the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of _____.
(Patient's Name)

I acknowledge receipt of the practice's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. I understand that the practice has reserved a right to change its privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me and/or available to me on the Chester County Pediatrics website - chestercountypediatrics.com.

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 practice. I also understand that I will not be able to revoke this consent in cases where the practice 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 _____.

Receipt of Notice of Privacy Practices Form

I, _____, hereby acknowledge receipt of the Notice of Privacy Practices.
(Patient's Name)

☐ Received Paper Copy ☐ Preferred website:chestercountypediatrics.com ☐ Individual refused to sign

Signed: _____**Date:** _____

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