WEE PEDIATRICS, INC.
Karen Ortiz, M.D.

Patient Consent to the Use and Disclosure of Health Information or Treatment, Payment, or Healthcare Operations

I understand, with this signed consent, Wee Pediatrics, Inc. may use and disclose my/my child's health information to carry out treatment, payment, and healthcare operations. I understand that as part of my healthcare, Wee Pediatrics, Inc. originates and maintains paper and or/electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. Please refer to our Notice of Privacy Practices for a more complete description of uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent and I have been provided with a copy to read.

Wee Pediatrics, Inc. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by sending a written request to Wee Pediatrics, Inc. Privacy Officer at 94-1388 Moaniani Street, Suite 207, Waipahu, Hawaii 96797.

I have the right to request that Wee Pediatrics, Inc. restrict how it uses or disclose my/my child's healthcare information to carry out treatment, payment, or healthcare operations. However, the practice is not required to agree to the restrictions requested. I may revoke my consent in writing, expect to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, due to the restrictions on disclosure of healthcare information and its effect on the ability to perform diagnosis and treatment, Wee Pediatrics, Inc. will be unable to provide treatment for my child.

I wish to have the following restrictions to the use or disclosure of my health information:

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_____

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I understand that as part of the Wee Pediatrics, Inc. treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

_____ _____
Patient's Name Date of Birth

_____ _____
Parent/Legal Guardian Name (Printed) Date

_____
Parent/Legal Guardian Signature

FOR OFFICE USE ONLY
[ ] Consent received by _____ on _____.
[ ] Consent refused by parent, and treatment refused, as permitted.
[ ] Consent added to the patient's medical record on _____.