



Bambini Pediatrics PC

Wholesome Medical Care for Kids

Consent For Use / Disclosure of Protected Health Information aka "The HIPPA Form"



With my consent, Bambini Pediatrics PC may use and disclose protected health information about me to carry out diagnosis, treatment, or collect payment (medical office functions). Please refer to Bambini Pediatrics' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Bambini Pediatrics reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Mark Sprankle, Privacy Officer at (207 Washington Street, Poughkeepsie, NY 12601).

With my consent, Bambini Pediatrics may:

- call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out medical office functions, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results.
- mail or fax to my home or other designated location any items that assist the practice in carrying out medical office functions, such as appointment reminder cards and patient statements.
- contact me by email regarding the same matters mentioned above.

I have the right to request that Bambini Pediatrics restrict how it uses or discloses my protected health information to carry out its medical office functions. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Bambini Pediatrics' use and disclosure of my protected health information to carry out its medical office functions.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Bambini Pediatrics may decline to provide treatment to me.

Signature of Parent/ Guardian of Patient

Name of Patient

Print Name of Authorized Signer

Date