CHILDREN'S CLINIC HIPAA CONSENT FORM

PATIENT NAME____ MRN #_______________

In signing this form, you consent to the use and disclosure of you or your child's protected health information by **The Children's Clinic of Billings, PC**, our staff, and our business associates, strictly for the purpose of treatment, payment, and health care operations.

You have the right, and we strongly encourage you, to review our **NOTICE OF PRIVACY PRACTICES** prior to signing this consent. It provides more detail on how we may use and disclose you or your child's information. The **NOTICE OF PRIVACY PRACTICES** may change at our discretion. A copy may be requested at either of our locations or a copy can be mailed to your residence. You may also view the Notice on our website (www.tccob.com).

Briefly, your rights include requesting an electronic or paper copy of you or your child's medical record, requesting an amendment to you or your child's medical record, requesting confidential communication from us, and requesting a list of those with whom we have shared information. You may also request that we restrict how we use and disclose you or your child's protected health information for the purposes mentioned above. If you would like to request a restriction, please ask for the ***Restricted Use and Disclosure*** form. We have the right, however, to deny your request in certain circumstances. In signing this form, you also consent for the Children's Clinic to send you appointment reminders via the contact information you provide on your account.

You may revoke this consent in writing at any point. Please refer to the **NOTICE OF PRIVACY PRACTICES** for further detailed information on your rights and the Children's Clinic's use and disclosure of protected health information in your child's medical record.

By signing this form, I grant my consent for The Children's Clinic of Billings, PC to use and disclose my or my child's protected health information for the purposes of treatment, payment, or health care operations.

____ __________________

Signature of Patient or Legal Guardian Date

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Relationship to Patient or Legal Authority (if applicable)

For Children's Clinic Use Only	Failure to Obtain Consent (check appropriate reason): □ Indirect treatment relationship □ Treatment required by law □ Substantial barriers in communication □ Emergency treatment □ Refusal to sign □ Other (describe below) Description of other:____
Clinic Employee Signature:____	Date: ______________