CONSENT TO DISCLOSE HEALTH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS

Patient Name:____**Date of Birth:**________________

Address:____

Telephone:____

ACKNOWLEDGEMENT OF RECEIPT OF PRACTICES NOTICE OF PRIVACY PRACTICES

By my signature below, I hereby acknowledge that I have received or have been offered, a copy of the Practices Notice of Privacy Practices.

CONSENT TO DISCLOSE MY GENERAL HEALTH INFORMATION:

By my signature below, I hereby authorize Mill Brook Pediatrics (MBP) to disclose my medical information so that MBP may treat me, seek payment from third parties for such treatment and generally carry on MBP health care operations (e.g., quality assurance). I also authorize the practice to disclose my medical information to insurers and providers outside of the practice when necessary so that these providers may treat me; seek payment for that treatment and for the purpose of their health care operations.

MY HIGHLY CONFIDENTIAL INFORMATION:

I understand that my medical record currently contains or may contain in the future the following types of highly confidential information. By my signature below, I specifically consent to the disclosure of such information as part of my medical record to insurers and providers outside MBP for the purpose of obtaining treatment for me, payment for the treatment provided to me and so that these entities can carry out their health care operations:

- Information about genetic testing
- Information related to confidential communications with a psychologist , social worker, allied mental health professional or human services professional
- Information about venereal disease(s)
- Information about family planning services
- If I am an emancipated minor, information about my treatment and diagnosis (except to my parents)
- Information about research involving controlled substances