

**PEDIATRIC ASSOCIATES OF ELIZABETHTOWN**

**111 Helmwood Plaza Drive, Elizabethtown, KY 42701**

**CONSENT**

I hereby consent to Pediatric Associates of Elizabethtown (the "Practice") using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I hereby authorize payment directly to them for medical and/or diagnostic benefits, including payment for any major medical benefits for services rendered during the course of treatment. I fully understand that I am obligated to pay the physician the balance due after insurance adjustment has been made and any collection fees incurred. I also understand that I am responsible for knowing the benefits of my insurance policy. I also consent to Practice using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Child

\_\_\_\_\_  
Description of Authority (i.e. parent)

**NOTICE OF PRIVACY PRACTICES**

I further acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information. The practice reserves the right to change the privacy practices outlined. I may obtain a new copy by submitting a written request to Melissa B. Flynn, M.D. at Pediatric Associates. I understand that I have the right to request restrictions on disclosures of my protected health information. The practice is not required to agree to any restriction but must comply if it does agree.

I have the right to revoke this consent in writing, except to the extent that action has already been taken.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Child

\_\_\_\_\_  
Description of Authority (i.e. parent)