Children's Surgical Associates
1814 Lucerne Terrace, Suite A
Orlando, FL 32806
407-540-1000 (Phone)
407-540-1011 (Fax)

Patient Name: ______________________________

HIPAA ACKNOWLEDGEMENT FORM/CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The Parent/Legal Guardian/Patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") and patient medical record information by Children's Surgical Associates (the "Practice") in order to carry out treatment, payment, or health care operations. The Parent/Legal Guardian/Patient should review the Practice's Notice of Privacy Practices for a more complete description of the potential uses and disclosures of such information, and has the right to review such Notice prior to signing this Consent Form.

The Practice reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the Practice does change the terms of its Notice of Privacy Practices, Parent/Legal Guardian/Patient may obtain a copy of the revised Notice.

Parent/Legal Guardian/Patient retains the right to request that the Practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the Practice does agree to requested restriction(s), such restrictions are then binding on the Practice.

Parent/Legal Guardian/Patient acknowledges and agrees that the Practice may disclose the patient's protected health information and patient's medical record information to the following individuals who are the Patient's family members, legal representatives, guardians, health care surrogates, or have power of attorney on behalf of the Patient. Individuals listed are also authorized to accompany patient to appointments. Government issued photo ID will be required for those listed below.

______________________________ ______________________________
Name Relationship to Patient

______________________________ ______________________________
Name Relationship to Patient

______________________________ ______________________________
Name Relationship to Patient

Parent/Legal Guardian/Patient agrees that the Practice may disclose the following types of information contained in the Patient's medical record. Please **initial** the appropriate categories listed below:

________ HIV/Aids Information

________ Mental Health Information

________ Substance Abuse Information

________ Sexually Transmitted Disease Information

________ Pregnancy information (if patient is under the age of 18)

Parent/Legal Guardian/Patient agrees and consents to the Practice releasing information to the Parent/Legal Guardian/Patient in the following manners. Please **initial** the appropriate categories below. If the Practice is contacted via phone, identifying information will need to be provided by the Parent/Legal Guardian/Patient to ensure patient confidentiality.

________ Home telephone/Answering Machine

________ Work phone/voice mail

________ Cell phone/voice mail

________ Via e-mail to the Parent/Legal Guardian/Patient's email address: ________________________

Requests for ANY faxed information (records, billing information, school notes, etc.) will need to be submitted in writing by the Parent/Legal Guardian/Patient to specify information requested, fax number where information is to be sent, and legal signature to be verified by photo ID on file

At all times, Parent/Legal Guardian/Patient retains the right to revoke this consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective *except* to the extent that the Practice has already taken action in reliance on the consent.

The Practice may refuse to treat the patient if Parent/Legal Guardian/Patient does not sign this consent form. If Parent/Legal Guardian/Patient signs this consent and then revokes it, the Practice has the right to refuse to provide further treatment to the patient as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEIVED A COPY OF THIS CONSENT (IF REQUESTED), AND I AM THE PARENT/LEGAL GUARDIAN/PATIENT, OR AM AUTHORZIED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

______________________________	______________________
Signature of Parent/Legal Guardian/Patient	Date
______________________________	______________________
Please print name	Relationship to patient