

**CAPITAL PEDIATRIC GROUP
ACKNOWLEDGEMENT TO THE USE AND DISCLOSURE OF HEALTH
INFORMATION FOR TREATMENT, PAYMENT, OR
HEALTHCARE OPERATIONS**

I understand that as part of my healthcare, Capital Pediatric Group produces and maintains health records describing my health history, symptoms, examination and diagnoses, treatment, and any plans for future care of treatment. I understand that this information serves as:

- * a basis for planning my care and treatment**
- * a means of communication among the many health professionals who contribute to my care**
- * a source of information for applying my diagnosis and surgical information to bill**
- * a means by which a third-party payer can verify that services billed were actually provided**
- * and a total of routine healthcare operations such as assessing quality and reviewing the competence of healthcare professional.**

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

I understand that I have the right to review the notice prior to signing this acknowledgement.

I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided.

I understand that I have the right to object to the use of my health information for directory purposes.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that I may revoke this acknowledgement in writing, except to the extent that the organization has already taken action in reliance thereon.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority