

Pediatric Surgical Associates of Fort Worth
901 Seventh Avenue, Suite 210
Fort Worth, Texas 76104

HIPAA Consent Form

I consent to the use or disclosure of my protected health information by Pediatric Associates of Fort Worth (PSA) for the purpose of diagnosing or providing treatment to my child or children, obtaining payment for my child/children's health and to conduct health care operations of PSA. I understand that diagnosis and treatment of my child or children by Pediatric Surgical Associates may be conditioned upon my consent as evidenced by the parent/legal guardian's signature on this document.

I understand I have the right to request a restriction as to how my protected health information is disclosed to carry out treatment, payment or healthcare operations of the practice. Pediatric Surgical Associates is not required to agree to the restrictions that I may request. However, if Pediatric Surgical Associates agrees to a restriction that I request, the restriction is binding on PSA and its physicians.

I have the right to revoke this consent, in writing, at any time, except to the extent that Pediatric Surgical Associates has taken action in reliance on this consent.

My "protected health information" means health information, including demographic information collected from me and created or received by my physician, another health care provider, and my employer or a health care clearing house. This protected health information relates to recent or future physical or mental health or condition and identifies my child/children, or there is a reasonable chance the information may identify my child/children.

I understand I have a right to review Pediatric Surgical Associates Notice of Privacy Practice that is also provided in the front office. The posted Privacy Practices also describes my right and the Pediatric Surgical Associates duties pertaining to my protected health information.

Pediatric Surgical Associates reserves the right to change the privacy practices that are posted on the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent by asking for one at the time of my next appointment.

Name of Patient

Date of Birth

Print Name of Patient's Parent or Legal Guardian

Signature of Patient's Parent or Legal Guardian

Date

Relationship to patient (parent/legal guardian)