# Consent for Release and Use of Confidential Information, Receipt of Notice of Privacy Practices Form, and Billing Information

I,_____, hereby give my consent to Kids First Pediatrics, Ltd. to use,
(Patient or authorized agent)

disclose, or release any medical information and copies of any medical records necessary to carry out treatment, process a related claim, or request payment of benefits directly to Kids First Pediatrics, Ltd.

I also authorize Kids First Pediatrics, Ltd. to release to my current and former insurance plans and any other physicians, any medical information and copies of medical records requested by those parties for the purposes including, but not limited to: office visits, hospitalizations, lab/medical testing, hospitalizations or insurance chart reviews.

For the purpose of patient communication, I authorize that Kids First Pediatrics, LTD has:

□ No restrictions (e.g. May leave messages on answering machine, send email, etc.)

□ Restrictions (e.g. Direct person-to-person communication with parent/guardian ONLY)

I acknowledge receipt of the office's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that Kids First Pediatrics has reserved a right to change the privacy practices that are described in the Notice. I also understand that a copy of any revised notice will be provided to me or made available to me in the office or on the web site.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so to Kids First Pediatrics, LTD. I also understand that I will not be able to revoke this consent in cases where Kids First Pediatrics, LTD has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

The insured/responsible party will pay for any fees applied to a yearly deductible or co-pay. The insured/responsible party will also remit payment for any unpaid claims which are 60 days or more past due. It is the insured/responsible party's responsibility to know their individual insurance plan's benefits and the insured/responsible party agrees to pay all fees not covered by their individual insurance plan within 60 days of billing.

Signed: _____ Date: _____

Name of Patient: _____
(Please Print)

If you are not the patient, please specify your relationship to the patient:

_____