PATIENT CONSENT FORM

By signing this form, you are giving consent to Northside Pediatrics, P.C. to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice Of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage that you read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by calling the office, 269-962-6221, and if a revision has been done you may pick one up or we will mail you one upon request.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we have already used or disclosed your protected health information in reliance on your consent.

Signature:_____ _____

of Patient Representative — Relationship of Patient Representative to Patient

_____ _____

Signature or Name of Patient — Date

PF-2000 Acknowledgement of Receipt of Notice of Privacy Practices

Northside Pediatrics P.C. reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the Notice of Privacy Practices for Northside Pediatrics.

_____

Name of Patient (Print or Type)

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Patient Representative to Patient

Northside Pediatrics, PC
265 Fremont Street
Suite 1
Battle Creek, MI 49017
269-962-6221

Receipt of Notice of Privacy Practices

I, _____, hereby acknowledge receipt of the Notice of Privacy Practices . The Notice of Privacy Practices provide detailed information about how the practice may use and disclose my confidential information.
I understand that the practice has reserved a right to change its 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.

Signed:_____ **Date:**_____

Patient's name_____

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

Mother_____
Father_____
Guardian____
Other_____ please fill in_____

Inability to Obtain Acknowledgment

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe the good faith efforts made to try and obtain the individual's acknowledgment, and the reasons why it was not obtained.
Signature of provider representative:_____ Date:_____

Reasons why the acknowledgment was not obtained
? Patient refused to sign
? Other or Comments

_____
_____
_____