

**CONSENT TO THE USE AND DISCLOSURE OF HEALTH  
INFORMATION FOR TREATMENT, PAYMENT, OR  
HEALTHCARE OPERATIONS**

**I consent to Northeast Cincinnati Pediatric Associates, Inc. using and disclosing protected health information about my child or his/her family to carry out treatment, payment or healthcare operations.** Examples of such instances include, but are not restricted to:

1. Local or State Medicaid Office
2. Your medical insurance carrier
3. Physicians to whom your child is referred
4. School health officials

I understand and have been provided with a Notice of Privacy Practices, which provides a more complete description of how our health information may be used or disclosed. I understand that I have a right to review the notice prior to signing this consent.

I understand that Northeast Cincinnati Pediatric Associates, Inc. reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from the office manager.

I have the right to revoke this consent by notifying Northeast Cincinnati Pediatric Associates, Inc. in writing, except to the extent that Northeast Cincinnati Pediatric Associates, Inc. has taken action in reliance on my consent. I understand that my revocation will take effect within 30 days after Northeast Cincinnati Pediatric Associates, Inc. receives it.

I understand that Northeast Cincinnati Pediatric Associates, Inc. may not be able to agree to a request from me to withhold my child's protected health information for treatment, payment, or healthcare operations.

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Signature of parent or legal guardian

\_\_\_\_\_  
Printed name of parent / guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient