RAINBOW PEDIATRICS

Consent to Use & Disclose Health information
Patients 18 years Old and Older

I understand that as part of my health care. Rainbow Pediatrics originates and maintains electronic records describing my health history, symptoms, examinations, and test results, diagnoses, treatments and any plans for future care or treatment.

I understand and have been provided access to a Notice of Privacy that provides a more complete description of information uses and disclosures. I understand that I have the right to review the Notice of Privacy prior to signing this consent.

PATIENT NAME:_____ **Date of Birth**:_____

I consent to the following uses of my medical information:

_____ I allow the following people complete access to my medical records

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

I ***DO NOT*** consent to the following use of my medical information:

_____ I do not wish for any of my medical records, diagnosis, treatment, etc. or financial information to be discussed with or released to anyone other than myself. I understand that I will be listed as the Responsible Party on my account with ***Rainbow Pediatrics*** and will be financially responsible for all charges incurred. I also understand that no one will be allowed to schedule appointment or receive medical advice on my behalf.

_____ _____
Signature of Patient Date