PEDIATRIC ASSOCIATES OF WELLESLEY, INC

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that if I want to receive treatment from one or more of the health care providers, ("Providers") associated with this Practice, I need to give permission for them to share information about my health, among themselves and with other individuals for treatment, billing purposes and other health care operations. I also understand that all reasonable efforts will be made to protect the privacy of my health information, whether it is maintained on paper or electronically, and regardless of the method by which it is communicated.

By signing below, I agree that any of the Providers associated with Pediatric Associates may:

1. Use my health information, on a need to know basis, to give me treatment.
2. Share my health information with others who are involved with my treatment either in or outside of this Practice.
3. Use my health information for billing purposes.
4. Share my health information with health insurance companies, government agencies, or other payors that request information related to benefits, claims filed, and other billing matters.
5. Share my health information either in or outside of this Practice for health care operations that include evaluation of the quality of heath care services your receive, and of the performance of the Providers to find better ways to provide care.
6. Share my health information with outside parties ("Business Associates") who contract with the practice to perform medical services on behalf of our patients. (ie: lab, radiology, night nurse triage, or for nebulizer equipment release)

Additionally, the Practice will generate Health Assessment Forms at annual physical examinations which provide information on current health and immunization status. These Forms will be given to me for my personal use and any further disclosure of this information I choose to make is at my personal discretion.

I understand that the Practice has a "Notice of Privacy Practices" ("Notice") that describes in detail (1) how my health care information is used and shared, (2) when I need to give further approval for the Providers to use and share my health information, (3) when my permission is <u>not</u> needed for the Providers to use and share my health information, (4) my rights regarding my health care information, and (5) grievance procedures if I believe my privacy rights have been violated.

I understand that I may request restrictions on the uses and disclosures of my health information. The Practice is not legally required to accept my request, but if it does, it will put any such restrictions in writing and abide by them except in emergency situations, or where required by law.

I understand that I have the right to receive a copy of the Notice and that I have the right to read the Notice before signing this Consent. I understand that Pediatric Associates of Wellesley, Inc. reserves the right to change the Notice at any time. I may obtain a current copy of the Notice by contacting the Practice at (781) 736-0040 (Weston office) or (508) 359-9200 (Medfield office).

I understand that I may revoke this consent, in writing, except to the extent that the Providers have already acted on it. I also understand that if I revoke this consent, the Providers have the right to refuse to provide further treatment to me.

I consent to the uses and disclosure of my health information as described above.

Signature of Patient or Legal Guardian/Representative:____________________________________

Print Name: ____________________________________ Date: __________________

Relationship To Patient: ____

Print Patient Name: ________________________________ Date of Birth ________________

REV: 6-17-03