CENTRAL OREGON
PEDIATRIC ASSOCIATES

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THIS CONSENT DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND RELEASED AND WHERE TO FIND MORE DETAILS ABOUT THIS. PLEASE REVIEW IT CAREFULLY.

NOTICE OF PRIVACY PRACTICES

Central Oregon Pediatric Associates Notice of Privacy Practices gives information about how Central Oregon Pediatric Associates may use and release protected health information about your family.

I Understand that:

- **I have the right to receive a copy of Central Oregon Pediatric Associates Notice of Privacy Practices.**
- **I may request a copy at any time.**
- **This notice may be revised.**
- **I am entitled to a copy of any revised Notice of Privacy Practices.**

By signing below, I acknowledge the above and that I have received or have been offered a paper copy of Central Oregon Pediatric Associates Notice of Privacy Practices.

CONSENT TO TREATMENT:

By signing below, I agree to receive medical care from Central Oregon Pediatric Associates.
I Understand that:

- **This consent to treatment will be in effect as long as I am seen at Central Oregon Pediatric Associates Clinics.**
- **I may cancel this consent in writing, except for the information that is already used or disclosed.**

CONSENT TO DISCLOSURE OF PROTECTED HEALTH INFORMATION:

My protected health information is made up of my child's health history, testing and treatment(s).
By signing this form, I understand and agree that Central Oregon Pediatric Associates may use or release my protected health information for the purposes of:

- **Providing treatment.**
- **Payment**
- **Healthcare operations**
- **As is reasonably necessary to comply with any court order, subpoena, or any other legal requirement(s) or regulation(s) as long as a separate authorization is not required under HIPAA regulations; or**
- **As in otherwise permitted under HIPAA regulations.**
- **I have the right to request a restriction of how my child's protected health Information is used. However, I also understand Central Oregon Pediatric Associates is not required to agree to the request. If Central Oregon Pediatric Associates agrees to my request restrictions, they must honor them.**

☐ **If needed this form was reviewed with me via an interpreter**

_____ _____
Print Patient's Full Name **Patient's Date of Birth**

_____ _____
Signature of Patient (or other legally authorized person) **Date**