COMBINED ACKNOWLEDGEMENT AND CONSENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Patient(s)' Name: _____

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes Lehigh Valley Pediatric Associates, Inc. to use and disclose health information about your child for treatment, payment, and healthcare operations purposes.

Notice of Privacy Practices. Lehigh Valley Pediatric Associates, Inc. has a Notice of Privacy Practices, which describes how we may use and disclose your child's protected health information and how you can access your child's protected health information and exercise other rights concerning your child's protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer

Mail: Lehigh Valley Pediatric Associates, Inc.
1251 S. Cedar Crest Blvd. • Suite 109 • Allentown, PA 18103
Attention: Privacy Officer
Telephone: (610) 434-2162
Facsimile: (610) 434-9370

Acknowledgement and Consent

Print or type all information except signature.

I have received the Notice of Privacy Practices for Lehigh Valley Pediatric Associates, Inc. and authorize them to use and disclose health information about

_____(patient's names)

for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____

Signature of patient (or patient's personal representative) Date

Personal representative information (if applicable):

_____ _____

Name of personal representative Relationship to patient (or other authority)