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### **HIPAA DISCLOSURE FORM**

I, \_\_\_\_\_ understand that as part of my healthcare, Excel Pediatrics originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care of treatment. I understand that this information serves as:

*\*A basis for planning my care and treatment*

*\*A means of communications among the many health professionals who contribute to my care*

*\*A source of information for applying my diagnosis and surgical information to my bill*

*\*A means by which a third-party payer can verify that services billed were actually provided and*

*\*A tool for routine health care operations such as assessing quality and reviewing the competence of healthcare professionals.*

*I understand and have been provided with a Notice of Privacy Policies that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges.*

*\*The right to review the notice prior to signing this consent*

*\*The right to object to the use of my health information for directory purposes and*

*\*The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.*

*I understand that Excel Pediatrics is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.*

*I further understand that Excel Pediatrics reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Excel Pediatrics change their notice, they will send a copy of any revised notice to the address we have on file to you.*

*I understand that as part of this organizations treatment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses including disclosures via fax.*

*I fully understand and \_\_\_\_\_accept or \_\_\_\_\_decline the terms of this consent.*

*Patient's Signature \_\_\_\_\_Date\_\_\_\_\_*

*Witness's Signature \_\_\_\_\_Date\_\_\_\_\_*