Consent for Purposes of Treatment, Payment and Healthcare Operations for Dr. Wanda Eppes & Associates

Patient Name _____. I consent to the use or disclosure of my/my child's protected health information by **Dr. Wanda Eppes & Associates** for the purpose of diagnosing or providing treatment to me/my child, obtaining payment for my health care bills or to conduct health care operations of **Dr. Wanda Eppes & Associates**. I understand that diagnosis or treatment of me/my child by **Dr. Wanda Eppes & Associates** may be conditioned on my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my/my child's protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Dr. Wanda Eppes & Associates** is not required to agree to the restrictions that I may request. However, if **Dr. Wanda Eppes & Associates** agrees to a restriction that I request, the restriction is binding on **Dr. Wanda Eppes & Associates**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Dr. Wanda Eppes or Dr. Wanda Eppes & Associates**, has taken action in the reliance on this consent.

My/my child's "protected health information" means health information, including demographic information, collected from me and created or received by my clinician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my/my child's past, present or future physical or mental health or condition and identifies my/my child, or there is a reasonable basis to believe the information may identify me/my child.

I understand I have a right to review **Dr. Wanda Eppes & Associates'** Notice of Privacy Practices prior to signing this document. **Dr. Wanda Eppes & Associates'** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my/my child's protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Dr. Wanda Eppes & Associates**. This Notice of Privacy Practices for **Dr. Wanda Eppes & Associates** is also posted on the licensing bulletin board in the office. This Notice of Privacy Practices also describes my rights and **Dr. Wanda Eppes & Associates'** duties with respect to my/my child's protected health information.

Dr. Wanda Eppes & Associates reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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If Client is a minor child:

_____ / _____ _____

Biological Mother Printed Name/ Signature Date

_____/ _____ _____

Biological Father Printed Name/ Signature Date

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If Client is an adult:

_____/ _____ _____

Client Name Signature Date