CARLOS ORTIZ MD PC
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Consent for the Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by Carlos Ortiz MD, or disclosed to others for the purposes of treatment, obtaining payment or supporting the day to day health care operations of practice.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for more complete description of how your protected health information may be used or disclosed. The Notice of Privacy Practice is available to you in the waiting area. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use and Disclosure of Your Information
You may request a restriction on the use and disclosure of your protected health information. Carlos Ortiz MD, may or may not agree to restrict the use and disclosure of your protected health care information. If Carlos Ortiz MD Pediatrics agrees to your request, the restriction will be binding of the practice. Use and disclosure of protected health information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use and disclosure that has already occurred prior to the date on which your revocation of your consent is received will not be affected.

Reservation of Right to Change Privacy Practices
Carlos Ortiz MD, reserves the right to modify the privacy practices outlined in the notice.

Signature
I have reviewed this consent form and give my permission to Carlos Ortiz MD, for the use and disclosure of my health information in accordance with this consent.

Patient Name:	
Signature of Parent or Guardian:	Date:
Please complete the following if this consent is signed by a personal representative on behalf of the patient	
Personal Representative's Name:	
Relationship to Patient:	

E-mail: _____