ROSENTHAL & SAMS PEDIATRICS AND ADOLESCENT MEDICINE
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Notice of Privacy Practices Acknowledgement

Our Notice of Privacy Practices (NOPP) provides information about how we may use and disclose health information about you. The NOPP contains a Patient Rights section describing your rights under the law. The terms of our NOPP may change. If we change our NOPP, you may request to review the changes by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction if we are otherwise allowed to disclose under the law, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of your protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior Consent. The patient and family understand that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a NOPP and the patient acknowledges that he/she has had an opportunity to review the NOPP.
- The Practice reserves the right to change the NOPP.
- The patient has the right to restrict use of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will cease.

Consent for Treatment

By signing below, I give Rosenthal and Sams Pediatrics and Adolescent Medicine, and its physicians, other medical professionals, employees, and personnel consent to provide, solicit and arrange for health care services, and prescribe medications when necessary, to my minor child named below. By signing below, I represent that I am either a parent with legal custody or the legal guardian of the minor child (patient) named below.

Patient Name (print)	Your Relationship to the Minor Patient

Your Name (print)	Your Signature	Date

Witness Name	Witness Signature	Date