Lynn Keefe, MD
pediatrics

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATION

I understand that as a part of my child's healthcare, **Lynn Keefe MD, Pediatrics**, will originate and maintain health records that describe my child's history, symptoms, examination, test results, diagnoses, treatment, and plans for future care or treatment.

I understand that these health records serve as:

- A basis for planning my child's care and treatment .
- A means of communication among the many health professionals who contribute to my child's care.
- A source of information for applying my child's diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.

I understand and have been provided/offered a copy of the Notice of Information and privacy practices which provides a more complete description of information uses and disclosures.
I understand that **Lynn Keefe MD, Pediatrics** reserves the right to change its notices and practices.
If changes are made **Lynn Keefe MD, Pediatrics** will notify me. I may request restrictions in writing.
I understand and accept the above information.

Patient Name (Please Print)

/ /

Parent/Guardian Signature

Date

Home Phone

Cell Phone