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VALLEY CHILDREN'S CLINIC, PLLC
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CONSENT

I give Valley Children's Clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies and for health care quality reviews.

I have been informed that I may review the clinic's Notice of Privacy Practices for a more complete description of uses and disclosures before signing this consent.

I understand that Valley Children's Clinic has the right to change their privacy practices and I may obtain any revised notices at the clinic.

I understand that I have the right to request a restriction of how my protected health information will be used. However, I also understand that Valley Children's Clinic is not required to agree to the request. If the clinic agrees to my requested restriction, they must follow the restrictions.

I also understand that I may revoke this consent at any time by making a request in writing except for information already used or disclosed.

Signature of Parent or Guardian_______________________________________

Date__________________________

Patient's
Name___________________________Birthdate__________________