Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by **Pediatric Endocrinology Associates.** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Pediatric Endocrinology Associates.**. I understand that diagnosis or treatment of me by **Mario I. Brakin, M.D. Pablito G. Nagpala M.D., M.D., Rebecca Hicks, M.D., or Mary E Patterson, M.D.** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Pediatric Endocrinology Associates** is not required to agree to the restrictions that I may request. However, if **Pediatric Endocrinology Associates** agrees to a restriction that I request, the restriction is binding on **Pediatric Endocrinology Associated** and **Mario I. Brakin, M.D. Pablito G. Nagpala, M.D., Rebecca A Hicks, M.D., and Mary E. Patterson, M.D.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Mario I. Brakin, M.D. Pablito G. Nagpala, M.D., Rebecca A Hicks, M.D.,Mary E. Patterson,M.D. or Pediatric Endocrinology Associates** has taken action in reliance on this consent.

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

I understand I have a right to review **Pediatric Endocrinology Associates**'s Notice of Privacy Practices prior to signing this document. The **Pediatric endocrinology Associates** 's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Pediatric Endocrinology Associates** The Notice of Privacy practices for **Pediatric Endocrinology Associates** is also provided **2650 Elm Avenue, Suite 210 Long Beach, CA 90806**.This Notice of Privacy Practices also describes my rights and the **Pediatric Endocrinology Associates**'s duties with respect to my protected health information.

Pediatric Endocrinology 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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Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority