Cedar Park Pediatric & Family Medicine
Southwest Pediatric Associates
Treehouse Pediatrics

Consent to Treat

Consent to Use & Disclose Health Information

Patients 18 Years and Older

This office is required by federal regulations to inform our patients in regards to the use of their health information in accordance to Health Insurance Portability & Accountability Act of 1996 or HIPAA.

I understand that as part of my healthcare, Austin Health Partners originates and maintains electronic records describing my health history, symptoms, examination and test results, diagnoses, treatments and any plans for future care or treatment.

I understand that as of my 18th birthday, I am considered an adult. Therefore, I need to give written consent to discuss my medical information with anyone other than myself, including my parents.

By signing this form I am designating the parties below with whom I wish Austin Health Partners to be able to discuss my medical information with. I understand that it is my responsibility to inform Austin Health Partners in writing of any changes pertaining to this release.

I, _____, hereby authorize Austin Health Partners to discuss with and release medical information to the individuals below. This release is written without restriction and includes information to mental health.

Name:_____ Relationship to Patient:_____
Name:_____ Relationship to Patient:_____
Name:_____ Relationship to Patient:_____

I understand that as a part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity. I hereby consent to such disclosure for these permitted uses.

I fully understand and accept the terms of this consent.

_____

Signature Date