Tosa Pediatrics
Drs. Richer, Martin, Timm, S.C.
8651 W. North Avenue
Wauwatosa WI 53226
414 774-9200

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION, PAGE 1 OF 2

Disclaimer

1. Permission to Use and Disclose My Health Information. By signing this form, I give Drs. Richer, Martin, Timm, S.C. permission to use and/or disclose my/my child's/children's health information to carry out treatment, payment, or health care operations.

2. Right to Refuse. I have the right not to sign this consent. If I refuse to sign this consent, Drs. Richer, Martin, Timm, S.C. will not provide me with treatment until I consent. However, treatment required by law, such as emergency care, can be provided to me whether or not I sign this consent.

3. Right to Review Notice of Privacy Practices. Upon request, Drs. Richer, Martin, Timm, S.C. will provide me with a copy of their Notice of Privacy Practices which describes how Drs. Richer, Martin, Timm, S.C. may use and disclose my health information. I have the right to review this Notice before signing this consent.

4. Changes to the Privacy Notice. Drs. Richer, Martin, Timm, S.C. may change the Notice of Privacy Practices as needed. I may obtain a current copy of Drs. Richer, Martin, Timm, S.C.'s "Notice of Privacy Practices" by contacting any office representative.

5. Right to Request Restrictions on Use/Disclosure. I have the right to request that Drs. Richer, Martin, Timm, S.C. restrict how they use and/or disclose my protected health information for the purpose of providing treatment, obtaining payment for services, and/or conducting health care operations. Drs. Richer, Martin, Timm, S.C. is ***not required*** to agree to any restriction I request. If Drs. Richer, Martin, Timm, S.C. does decide to agree to my request, they must restrict their use and/or disclosure of my health information the way I asked. Because of the number, complexity, and nature of the services they deliver, Drs. Richer, Martin, Timm, S.C. will rarely agree to requests to restrict uses and disclosures of my health information for the purposes of treatment, payment, and healthcare operations. If I wish to request restrictions I can contact any office representative. Drs. Richer, Martin, Timm, S.C. will notify me of their decision to accept or decline my restrictions.

6. Right to Withdraw Consent. I have the right to withdraw this consent at any time. I must do this in writing. If I want to withdraw this consent, I can contact any office representative of Drs. Richer, Martin, Timm, S.C.. Note that my withdrawal of this consent will ***not*** be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then Drs. Richer, Martin, Timm, S.C., by law, is unable to provide to me further treatment or follow-up, other than required emergency services.

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CONSENT TO USE AND DISCLOSE HEALTH INFORMATION, PAGE 2 OF 2

7. Effective Period. This consent is good unless and until I withdraw it in writing.

8. References to "I" or "me". References to "I" or "me" in this Consent include the individual for whom the signing party is authorized to sign. If I am signing this consent on behalf of another person, it is because I am the legal guardian, parent, or agent under an active Power of Attorney for Health Care, and am legally authorized to sign this Consent on behalf of the individual.

Parent/Patient Signature Printed Name Date

If Patient is unable to sign, please indicate reason(s) why below:

☐ This is an emergency treatment situation and/or Drs. Richer, Martin, Timm, S.C. is required by law to treat the patient and has attempted to obtain the patient's consent but he/she is unable to sign the consent.

☐ The patient is a minor, thus the legal guardian, parent, or agent under active Power of Attorney for Health Care is signing on his/her behalf.

☐ There are substantial barriers to communicating with the patient and Drs. Richer, Martin, Timm, S.C. determines that the patient's consent to receive treatment is inferred from the circumstances.

THIS COMPLETES THE CONSENT FORM PORTION OF THIS FORM

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Insurance Information (Please read; this is *separate* from above consent form.)

I hereby request and authorize my insurance company/companies to pay directly to Drs. Richer, Martin, Timm, S.C. any proceeds payable under the terms of my policy/policies. I also understand and agree that any unpaid balance not covered by this policy is my obligation and will be paid by me within the guidelines of Drs. Richer, Martin, Timm, S.C. I hereby give consent to Drs. Richer, Martin, Timm, S.C. to release medical information pertaining to my care/claim to my insurance company/companies.

Signature Printed Name Date

Children's Names (First & Last)

_____ _____
_____ _____
_____ _____