ANGEL PEDIATRICS, PA
717 S GREENVILLE AVE. SUITE 104
ALLEN, TX 75002
(972) 396-1900

PF 2000 ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Notice of Privacy Practices: You have the right to read our Privacy Practices before you decide whether or not to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses of disclosures we make of your protected health information, and all of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing the consent.

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Right to revoke: You will have the right to revoke this consent at anytime by giving us written notice of your revocation submitted to the contact person listed on the Privacy Practice. Please understand that the revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Our practice reserves the right to modify the practices outlined in the notice.

SIGNATURE:

I, _____ have had full opportunity to read and consider the contents of the consent form and your Notice of Privacy Practices. I understand by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare questions.

Signature: _____ Date: _____

If a personal representative on the behalf of the patient signs this consent, please complete the following:

Personal Representative's Name: _____

Relationship to patient: _____