CONSENT TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION AND AUTHORIZATION

I, ____ the parent/guardian of the child named as ______________________________________ and related to me as _____________and this patient is covered under my health plan___________________________ living at __________________ give this PEDIATRIC PRACTICE of Vijaya Radhakrishna, M.D. and her associates our consent to use and disclose any and all protected health information created by this practice and/or maintained in my child's "medical record" (defined to include all medical reports, diagnosis, clinical abstracts, case histories, proposed treatment, payment or health plans and prognosis, insurance information and/or any other information) as necessary to carry out treatment, payment or health care operations.

I, ____ the parent/guardian of the above noted patient here by authorize this pediatric practice of Dr. Vijaya Radhakrishna, M.D., and associates and whom so ever. Dr. Vijaya Radhakrishna may designate as her assistant(s) to perform diagnostic tests and to administer treatment, as he/she seems necessary to my child, whose name is ____.

AUTHORIZATION FOR PAYMENT

I, here by agree that I am financially responsible to this pediatric practice for all co pays, coinsurance, deductibles, and fees for non-covered services that are rendered to my child. To the best of my knowledge, I have furnished this pediatric practice all accurate information regarding my family health insurance including my child's health insurance. If any inaccuracies should occur, which will result in non-payment, I will be responsible for full payment of all services rendered.

Signature of Parents/Guardian of patient _______________________________ Date _______________

I, the parent/guardian of the above noted patient, understand that this pediatric practice may refuse to provide treatment to my child, if I do not execute this consent. I further understand that I have the right to request that the above noted pediatric practice restrict how my child's medical record is used or disclosed to carry out the treatment, payment, or health care operations. However this pediatric practice is not required to agree with my requested restrictions. If this pediatric practice agrees to my requested restriction such restrictions will be binding on this pediatrics practice.

I the parent/guardian of the above noted patient understand that the terms of this consent is governed by the Health Insurance Portability and Accountability act of 1996, and it's implementing regulations (HIPPA). I understand that I have the right to revoke this consent at any time except to the extent that this pediatric practice has taken action in reliance, therefore, I understand that any revocation must include the patient name, my name, address, telephone number, date of this consent and my signature and that I should send it to the HIPPA privacy Officer at:

Dr. Vijaya Radhakrishna and Associates

155 Stelton Rd
Piscataway, N.J. 08854

230 Route 18 North
East Brunswick, N. J. 08816