KEVIN BRUCE NOROWITZ, MD, FAAP
YOCHEVED R BERGMAN, PA-C

Pediatrics & Adolescents Medicine

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Brooklyn, New York 11218
(718) 435 – 5009

LEVEL 3 CERTIFIED

Consent to Use & Disclose Health Information

Patients 18 years & older

Patient's Name: _____ **DOB**: _____

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 HIPPA.

PLEASE READ THE FOLLOWING CAREFULLY!

I understand that as part of my health care, Dr. Kevin Bruce Norowitz, MD, FAAP (*the organization*), originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatments, and any plans for future care or treatment.

I understand that I have the right to review the *Notice of Privacy Practices* prior to signing this consent, allowing treatment, or making payment for services rendered.

I understand that *the organization* is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization may refuse to treat me as permitted by Federal Regulations. I understand that *the organization* reserves the right to change their *Notice of Privacy Practices*.

I consent to the following uses of my medical information: (Please chose 1 option below & initial next to your choice)

_____ I allow the following people complete access to my medical records.

_____ _____
Full Name Relationship

_____ _____
Full Name Relationship

_____ _____
Full Name Relationship

I understand that as 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 also hereby consent to such disclosures via fax. **I fully understand and accept the terms of this consent**.

OR

_____ I do not wish for any of my medical (medical records, diagnosis, treatment, etc.) or financial information to be discussed with or released to anyone other than myself. I understand that I will be listed as the Responsible Party on my account with *the organization* and will be financially responsible for all charges incurred. I also understand that no one will be allowed to schedule appointments or receive medical advice on my behalf.

Patient's Signature: _____ **Date**: _____

eMail: doc@drnorowitz.com
Patient Portal: https://www.drnorowitz.com