Coastside Pediatric Therapy Center

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

By signing this form, you acknowledge receipt of the Notice of Private Practices of Coastside Pediatric Therapy Center. Our Notice of Private Practices provides information about how we may use and disclose your child's protected health information. We encourage you to read it in full.

This signed form indicates your consent for Coastside Pediatric Therapy Center to disclose appropriate health information for the purpose of analyzing, diagnosing, or providing treatment to your child, obtaining payment for your health care bills or to conduct research.

You have the right to request a restriction as to how your child's health information is used or disclosed to carry out treatment, payment or operations of the practice.

Your child's "protected health information" means health information, including demographic information, collected from you and created or received by the treating therapist. This protected health information relates to your child's past, present or future physical or mental health or condition and identifies your child.

Our Notice of Private Practices is subject to change. If we change our notice, we will provide you with the revised notice or you may obtain a copy of the revised notice by contacting our office at (650) 560-9470 or (650) 560-9471. If you have any questions about our Notice of Private Practices, please contact us.

Name of client: _____

_____ _____

Signature of Legal Guardian Printed Name of Guardian

_____ _____

Relationship of Legal Guardian Date of signing

255 Main Street Half Moon Bay, CA 94019 (650) 560-9471 FAX (650) 560-9428