DEVELOPMENTAL PEDIATRICS
HEALTH & WELLNESS PC
DR ASMA J SADIQ, MD FAAP

HIPAA/Prescription CONSENT FORM

I give Developmental Pediatrics Health/Wellness, PC my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, to view any past prescription histories, and for health care operations like quality review.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for the information already used or disclosed.

Parent Signature______________________________ Date____________________

661 E Palisades Ave, Ste 4A, Englewood Cliffs, NJ 07632
t 201 408 4777 / 646 343 9070 f 201 408 4661