PEDIATRIC ASSOCIATES, PC

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Pediatric Associates, PC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (The Notice of Privacy Practices for Pediatric Associates, PC provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Pediatric Associates, PC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Susan Headrick, Privacy Officer of Pediatric Associates, PC at 3000 Johnson Ferry Rd. Suite 204, Marietta, Georgia 30062.**

With this consent, Pediatric Associates, PC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders. Insurance items and any call pertaining to my clinical care, including laboratory results among others.

With this consent, Pediatric Associates, PC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Pediatric Associates, PC may fax or e-mail to my home or other alternate location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Pediatric Associates, PC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I give Pediatric Associates, PC my consent for use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Pediatric Associates, PC may decline to provide treatment to me.

______________________________	______________________________
Patient Name	Date of Birth
______________________________	______________________________
Signature of Parent or Guardian	Date