CONSENT FORM

For Use and Disclosure of Protected Health Information (PHI) for Treatment, Payment, or Healthcare Operations (TPO)

I understand that as part of my child's healthcare, Calvary Pediatrics originates and maintains health records describing health history, symptoms, examination and test results, diagnosis, treatment, and plans for future care and treatment. I also understand this information serves as : 1) A basis for planning care and treatment, 2) A means of communication among the many health professionals who contribute to my child's care, 3) A source of information for applying diagnosis and surgical information to my child's bill, 4) A means by which a third party payer can verify that services billed were actually provided, 5) And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a **Notice of Information Practices** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand the Practice reserves the right to change their notice and practices, and prior to implementation, will mail a copy of any revised notice to the address that I have provided if there is a need to use or disclose any protected health information. I also understand that I have the right to restrict as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice 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 Practice has already taken action in reliance thereon.

With this consent, Calvary Pediatrics may call my home or other designated 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 child's clinical care.

With this consent, Calvary Pediatrics may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as lab results and other correspondence as long as they are marked "Personal and Confidential".

By signing this form, I am consenting to Calvary Pediatrics to use and disclose my child's 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, Calvary Pediatrics may decline to provide treatment to my child.

Print Patient Name: ____

Signature of Parent/Guardian: ______________________________Date: ______________