Patient Consent for the use and disclosure of Protected Health Information

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It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this document is to ensure that our practice and its physicians and staff hove our patients' consent to use necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of our patients' information. Please review the following agreement:

I hereby give my consent for the above pediatric practice to use and to disclose protected health care information about me to carry out treatment, payment and healthcare operations. The Privacy Practices Notice provides a more complete description of such uses and disclosures.

I have the right to review the Privacy Practices Notice prior to signing this consent. The pediatric practice reserves the right to revise it Privacy Practices Notice at anytime. A revised Privacy Practices Notice may be obtained by forwarding a written request to the above listed practice at 1001 Jones Street, Reno, NV 89503.

With this consent, the practice may call my home or other alternative location and leave a message on voice mail or in person in reference to any of the items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and calls pertaining to clinical care.

***Please print the telephone number of where you would like to receive any phone calls from our office if other than your home:**

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With this consent, the practice may mail or e-mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

***Please print the address of where you would like any correspondence from our office to be sent if other than your home:**

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By signing this form, I am consenting to the above pediatric practice's use and disclosure of my protected health care information to carry out needed treatment, payment and healthcare operations.

*** I authorize the Practice to disclose my medical information to the following family members/friends:**

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I may revoke or limit 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, the practice may decline to provide treatment to me.

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Signature of Parent or Legal Guardian Patients Name

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Print Name of Parent or Legal Guardian Date