Pinelands Pediatric Medicine, LLC

Patient Consent/Authorization For Use & Disclosure Of Protected Health Information

I hereby give my consent for Pinelands Pediatric Medicine, LLC to use and disclose protected health information (PHI) about my child/me to carry out treatment, payment and health operations. The notice of Privacy Practices, provided by Pinelands Pediatric Medicine, describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Pinelands Pediatric Medicine reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request with a self-addressed stamped envelope to Pinelands Pediatric Medicine.

With this consent, Pinelands Pediatric Medicine may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment and health operations, such as reminder cards, insurance items and any calls pertaining to my child's/ my clinical care, including laboratory test results, among others.

With this consent, Pinelands Pediatric Medicine may mail or fax to my home or other alternative location any items that assist the practice in carrying out treatment, payment and health operations, such as but not limited to, reminder cards and patient statements.

I have the right to request the Pinelands Pediatric Medicine restrict how it uses or discloses my/my child's PHI to carry out treatment, payment and health operations. The practice is not required to agree to my requested restrictions, but if it does, it is bound to this agreement.

By signing this form, I am consenting to allow Pinelands Pediatric Medicine to use and disclose my PHI to carry out treatment, payment, and health operations. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

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, Pinelands Pediatric Medicine may decline to provide treatment to me/my child.

Signature Patient/Parent/Legal Guardian_____

Patient Name_____ Date_____