PHI Policy

Policy

Patient Consent For Use and Disclosure of Protected Health Information

I hereby give my consent for Healthy Start Pediatrics, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO).

I have reviewed the Notice of Privacy Practices prior to signing this consent. Healthy Start Pediatrics, LLS reserves the right to revise this Notice of Privacy at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Healthy Start Pediatrics, LLC Privacy Officer at 1745 Avenida de Mercado, Las Cruces, NM 88005.

With this consent, Healthy Start Pediatrics, LLC 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 TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others. Healthy Start Pediatrics, LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, as long as they are marked Personal and Confidential.

With this consent, Healthy Start Pediatrics, LLC may e-mail to my home or other alternative location any items that assist the practice in carrying our TPO. I have the right to request that Healthy Start Pediatrics, LLC 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 am consenting to Healthy Start Pediatrics, LLC's use and disclosure of my PHI to carry out TPO. I am also acknowledging that I have received Healthy Start Pediatrics, LLC's Notice of Privacy Practices.

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, Healthy Start Pediatrics, LLC may decline to provide treatment to me.

Patient Name:
Date: