pediatric care corner

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Pediatric Care Corner, P.C. may use and disclose protected health information (PHI) about me or my child(ren) to carry out treatment, payment, and healthcare operations (TPO). Please refer to Pediatric Care Corner, P. C's Notice of Privacy Practices for 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 Care Corner, P.C. 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 to **John Boyle, D.O., Privacy Officer, Pediatric Care Corner, P. C., 2300 Haggerty Road, Suite 2110, West Bloomfield, MI 48323.**

With my consent, Pediatric Care Corner, P. C. may call my home or other designated 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 call pertaining to my clinical care, including laboratory results among others.

With my consent, Pediatric Care Corner, P.C. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Pediatric Care Corner, P. C. may email to me my appointment reminder cards and patient statements. I have the right to request that Pediatric Care Corner, P. C. restrict how it uses or disclosed 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.

With my consent, Pediatric Care Corner, P.C. may obtain my prescription history and preferred medications from a centralized database to assist in my care and determining appropriate prescription medications.

By signing this form, I am consenting to Pediatric Care Corner, P. C.'s 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, Pediatric Care Corner, P. C. may decline to provide treatment to me or my child(ren).

_____
Print Patient's Name

_____
Print Name of Parent or Legal Guardian

_____ _____
Signature of Parent, Patient, or Legal Guardian Date Signed