NOVA
PEDIATRICS
AND YOUNG ADULT MEDICINE

REV 11/23/2018

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

With my consent, Nova Pediatrics, Ltd. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Nova Pediatrics 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. Nova Pediatrics reserves the rights 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 Nova Pediatrics Privacy Officer at 6120 Brandon Avenue, Ste 308, Springfield, VA 22150.

With my consent, Nova 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 clinical care, including laboratory results among others.

With my consent Nova Pediatrics 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 as long as they are marked Personal and Confidential.

With my consent, Nova Pediatrics may e-mail to me appointment reminder cards and patient statements. I have the right to request Nova Pediatrics 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 Nova Pediatrics' 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, Nova Pediatrics may decline to provide treatment to me.

_____   _____
Signature of Patient or Legal Guardian   Print Name of Patient or Legal Guardian

Patient's Name _____   DOB _____

Patient's Name _____   DOB _____

Patient's Name _____   DOB _____