WESTCHASE PEDIATRIC CARE

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

I _____ have reviewed a copy of WESTCHASE PEDIATRIC CARE's Notice of Privacy Practices

Updated for the 2013 HITECH Omnibus Rule

With my consent, WESTCHASE PEDIATRIC CARE may use and disclose protected health information about me/my child to carry out treatment, payment and healthcare operations (TPO). (Please refer to WESTCHASE PEDIATRIC CARE's Notice of Privacy Practices for a more complete description of such uses and disclosures). I have the right to receive a copy of "Notice of Privacy Practices" prior to signing this consent. WESTCHASE PEDIATRIC CARE reserves the right to revise its Notice of Privacy Practices at any time. If revised, a copy of the new Notice of Privacy Practices will be posted on the office bulletin board, the office website and a copy of the same may be obtained by forwarding a written request to WESTCHASE PEDIATRIC CARE, 10941 Countryway Blvd, Suite A, Tampa FL 33626.

With my consent, WESTCHASE PEDIATRIC CARE may call my home or other designated locations 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 child's clinical care, including laboratory results among others.

With my consent, WESTCHASE PEDIATRIC CARE 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.

I have the right to request that WESTCHASE PEDIATRIC CARE restrict how it uses or discloses my child's 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 WESTCHASE PEDIATRIC CARE's use and disclosure of my child's PHI to carry out TPO. I have the right to revoke my consent. If I do not sign this consent, WESTCHASE PEDIATRIC CARE may decline to provide treatment to my child.

_____ _____

Signature of Legal Guardian | Print Name of Legal Guardian

_____ _____

Print Name of Patient | Date