

FOREST PARK PEDIATRICS, P.C.

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Forest Park Pediatrics, P.C. may use and disclose protected health information (PHI) about me or my child, _____, date of birth, _____, to carry out treatment, payment and healthcare operations (TPO). Please refer to the Forest Park Pediatrics, P.C. 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. Forest Park Pediatrics, P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Forest Park Pediatrics, P.C. Privacy Officer, 4488 Forest Park Avenue, Suite 230, St. Louis, MO 63108.

With my consent, Forest Park Pediatrics, P.C. may call my home or other designated location and leave a message on voice mail or in person to myself, child's grandparent or other consenting adult, 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 normal laboratory results and information of scheduled tests among others.

With my consent, Forest Park Pediatrics, P.C. may mail to my home or other designated location any items that assist the practice in carrying out TPO including appointment change notifications, patient statements and requests for additional information.

I have the right to request that Forest Park Pediatrics, P.C. 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 Forest Park Pediatrics, 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, Forest Park Pediatrics, P.C. may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Date

Print Name of Patient or Legal Guardian