Parent/Patient Consent for use and Disclosure of Protected HEALTH INFORMATION

We take our responsibility to protect your child's health information seriously. We will, as always, safeguard this information and only use it as specified by the **"Notice of Privacy Practices".**

With my consent, **O & P in Motion, Inc.** may use and disclose protected health information in order to carry out treatment, payment and health care operations.

With my Consent this practice may;	**Circle One**	
Call my home and leave a message	**YES**	**NO**
Send reminders for appointments by mail	**YES**	**NO**
Give information to the school regarding health status	**YES**	**NO**
Speak to other members of my household by telephone	**YES**	**NO**

If you have anyone who you do not wish for us to speak to in your household please give us their specific names;

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At this practice **Phillip P. Ambroset, C.P.O.** may request the use of digital photos to treatment as well as during treatment. These will be used only to benefit your child. These photos will be taken in a modest manner that will never expose identity of the patient. On a rare occasion we may request that these photos be used for research or to enlighten some one as to the conditions and or treatment. If we request photos for one of these reasons we will ask for separate permission for these types of photo. If you request we will provide you with a copy of any photographs taken.

Do we have permission to take photographs as described above? YES NO

This agreement will be kept in the patients chart. A copy of this or our Notice of Privacy Practices may be requested at any time. You have a right to amend this agreement at any time.

_____
Print Patient's Name

_____ _____
Signature of Parent or Legal Guardian **Date**