Patient Consent for Use and Disclosure of Protected Health Information

I hereby grant my consent for CareVille Pediatrics P.A to use and disclose Protected Health Information (PHI) about my child/ren to carry out treatment, payment and healthcare operations (TPO).

With this consent, CareVille Pediatrics P.A may **CALL** my home or other alternative location and leave a message on voice mail or in person regarding any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my child/ren clinical care, including laboratory results among others.

My home number _____ message to call office/detailed message.
My work number _____ message to call office/detailed message.
My cell phone number _____ message to call office/detailed message.

I consent, CareVille Pediatrics P.A, may **MAIL** to my home or alternative location any times that may assist the practice in carrying out TPO, which may include appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

Address for mailings: _____

I consent, CareVille Pediatrics P.A to **E-MAIL** to my home or other alternative location any items that assist the practice in carrying out TPO, which may include appointment reminder cards and patient statements. I have the right to request that CareVille Pediatrics P.A restrict it's uses or discloses my request restrictions, but if it does, it is bound by this agreement.

E-Mail Address: _____

By signing this form, I am consenting to CareVille Pediatrics P.A 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.

Patient Name: _____

Printed Name of Parent/Legal Guardian: _____
Signature of Parent/Legal Guardian: _____ Date: _____