

# PEDIATRIC ASSOCIATES OF LANCASTER, INC.

## Patient Consent for Use and Disclosure Of Protected Health Information

With my consent, Pediatric Associates of Lancaster, Inc. may use and disclose protected health information (PHI) about me or my child to facilitate treatment, payment and healthcare operations (TPO.)

With my consent, Pediatric Associates of Lancaster, Inc. may call my home or other designated location and leave a message on voice mail or in person in reference to all items that assist the practice in implementing 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, Pediatric Associates of Lancaster, Inc. may mail to my home or other designated location any items that assist the practice in implementing TPO, such as appointment reminder cards and patient statements, provided they are marked "Personal and Confidential."

With my consent, Pediatric Associates of Lancaster, Inc. may e-mail my appointment reminder cards and patient statements.

I have the right to request that Pediatric Associates of Lancaster, Inc. restrict how it uses or discloses my PHI in the implementation of TPO. However, the practice is not required to agree to my requested restrictions. If the practice does agree, however, it is bound by this agreement.

I have the right to review the Pediatric Associates of Lancaster Inc. Practice Privacy Notice prior to signing this consent.

Pediatric Associates of Lancaster Inc. reserves the right to revise its Practice Privacy Notice at any time.

A current Pediatric Associates of Lancaster Inc. Practice Privacy Notice may be obtained by forwarding a written request to: Privacy Officer, at Pediatric Associates of Lancaster, Inc, 1550 Sheridan Drive, Suite 102, LANCASTER OH 43130.

By signing this form, I am consenting to Pediatric Associates of Lancaster, Inc.'s use and disclosure of my PHI to implement 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, Pediatric Associates of Lancaster, Inc. may decline to provide treatment to me or my child.

\_\_\_\_\_  
**Signature** of patient, parent or legal guardian

\_\_\_\_\_  
**Print** name of patient, parent or legal guardian

\_\_\_\_\_  
Name(s) of Patient(s) - List names of **all** children we see

\_\_\_\_\_  
Date