

Patient Consent for Use and Disclosure of Protected Health Information

As parent/guardian of _____, I understand that as part of my child's health care Children's Oasis Pediatrics originates and maintains health records. These records describe history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Information Practices that describes uses and disclosures of my child's Protected Health Information (medical record). I understand that I have the right to review the notice prior to signing this consent.

With my consent, Children's Oasis Pediatrics may call (including leaving voice mail messages), mail, or e-mail my home regarding items that assist the practice in carrying out treatment, payment, and health care operations, such as appointment reminders, laboratory results, and insurance items.

I understand that Children's Oasis Pediatrics has the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address that I have provided.

I understand that I have the right to request restrictions as to how my child's health information may be used or disclosed to carry out treatment, payment, or health care operations and that Children's Oasis Pediatrics is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Children's Oasis Pediatrics has already taken action. If I do not sign this consent or revoke it, Children's Oasis Pediatrics may decline to provide treatment to my child.

I fully understand and I consent to Children's Oasis Pediatrics' use and disclosure of my child's Protected Health Information to carry out treatment, payment, and health care operations.

Parent / Guardian

Date