

Northeast Pediatrics & Adolescent Medicine, LLP

PATIENT HIPPA AWARENESS

With my permission, Northeast Pediatrics & Adolescent Medicine may use and disclose protected health information (PHI) about my child to carry out treatment, payment and healthcare operations (TPO). Please refer to Northeast Pediatrics & Adolescent Medicine’s 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. Northeast Pediatrics & Adolescent Medicine reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Northeast Pediatrics & Adolescent Medicine may call my home or other designated locations and leave a message on voice mail or in person 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 car, including laboratory results among others.

With my permission, the office of Northeast Pediatrics & Adolescent Medicine may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards as long as they are marked Personal and/or Confidential.

With my permission, the office of Northeast Pediatrics & Adolescent Medicine may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards. I have the right to request that Northeast Pediatrics & Adolescent Medicine 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, I am allowing Northeast Pediatrics & Adolescent Medicine to use and disclose my PHI for 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’s Name _____ **Date** _____

Signature of Parent or Legal Guardian

Print name of Parent or Legal Guardian