CHILD HEALTH PARTNERS

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PATIENT PRIVACY CONSENT FORM

In order to comply with the Health Insurance Portability and Accountability Act (HIPAA), to ensure patient confidentiality, and to maintain a professional atmosphere at Child Health Partners, P.C. we are required by law to provide you with this notice of our legal duties and privacy practices that we will maintain in our practice concerning your child. Please read the following sign and date.

- With my consent, child Health Partners may use and disclose protected health information (PHI) about my child to carry out treatment, payment and healthcare operations (TPO). Please refer to Child Health Partners Notice of Privacy Practices for a more complete description of such uses and disclosures.

- With my consent, Child Health Partners may call my child's name in the waiting room when my physician is ready to see the patient.

- With my consent Child Health Partners may contact me to remind me of my child's appointment by leaving a message at my home or designated location.

- With my consent Child Health Partners may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations (TPO).

- I have the right to review the notice of Privacy Practices prior to signing this consent.

By signing this form, I am consenting to Child Health Partners use and disclosure of my protected health information about my child to carry out treatment, payment and healthcare operations.

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 Child Health Partners may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

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Patients Name D.O.B. Date

1-15-16