Pediatrics of Arlington PLC

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Pediatrics of Arlington PLC may use and disclose **protected health information** (PHI) about my child to carry out **treatment, payment, and healthcare operations** (TPO). Please refer to Pediatrics of Arlington PLC'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.

With my consent, Pediatrics of Arlington PLC may call my home or other designated location 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 child's clinical care, including laboratory results among others.

With my consent, Pediatrics of Arlington PLC may complete forms with information regarding my child's health and immunization records, such as school and camp forms.

Pediatrics of Arlington PLC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as patient statements.

I have the right to request that Pediatrics of Arlington PLC restricts 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 form, I am consenting to Pediatrics of Arlington PLC's use and disclosure of my protected health information (PHI) to carry out treatment, payment, and healthcare options (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, Pediatrics of Arlington PLC may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian