PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

Patient's Name: ____ Date of Birth: ____________

With my consent, Southside Pediatrics may use and disclose **P**rotected **H**ealth **I**nformation (PHI) about my child to carry out **T**reatment, **P**ayment and healthcare **O**perations (TPO). Please refer to Southside Pediatrics Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review Notice of Privacy Practices prior to signing this consent. Southside Pediatrics reserves the right to revise its Notice of Privacy Practices at any time. A current copy of the Notice is available for me to review at the office location and available at the office web site: www.southside4kids.com and a revised Notice of Privacy Practices may be obtained by forwarding a written request to Southside Pediatrics 300 Meadow Run Drive, Hastings MI 49058 Attn: Medical Records.

With my consent, Southside Pediatrics may call my home, cell phone or other designated location and leave a message on voice mail in reference to any items that assist the practice in carry ing out TPO, such as appointment reminders, insurance items and any type of call pertaining to my child's clinical care, including laboratory results. I also acknowledge that my enrollment in the Southside Pediatrics patient portal is consent to have TPO published to a secured web site for the purpose of secure patient communication. I will abide by the rules and regulations published at the patient portal.

With my consent, Southside Pediatrics may mail to my home or other designated location, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Southside Pediatrics restrict how it uses or disclosed my child's PHI to carry out TPO. However, the practice in 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 Southside Pediatrics use and disclosure of my child's PHI to carry out 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, Southside Pediatrics may decline to provide treatment to my child.

ACKNOWLEDGEMENT

I acknowledge receipt of the *Southside Pediatrics Notice of Privacy Practice* and give permission to the use and disclosure of PHI and TPO.

____

Signature of Parent/Legal Guardian Date