CLEARWATER PEDIATRIC CARE

PATIENT CONSENT FOR USE AND DISCOLSURE OF PROTECTED HEALTH INFORMATION

I ________________________________ have reviewed a copy of CLEARWATER PEDIATRIC CARE's Notice of Privacy Practices

With my consent, CLEARWATER PEDIATRIC CARE may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations (TPO). (Please refer to CLEARWATER PEDIATRIC CARE's Notice of Privacy Practices for a more complete description of such uses and disclosures.) I have the right to receive a copy of "Notice of Privacy Practices" prior to signing this consent. CLEARWATER PEDIATRIC CARE reserves the right to revise its Notice of Privacy Practices at anytime. If revised, a copy of the new Notice of Privacy Practices will be posted on the office bulletin board and a copy of the same may be obtained by forwarding a written request to CLEARWATER PEDIATRIC CARE, 2370 Drew Street, Suite B, Clearwater, FL 33765.

With my consent, CLEARWATER PEDIATRIC CARE may call my home or other designated locations and leave a message on voicemail 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, CLEARWATER PEDIATRIC CARE 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 as long as they are marked Confidential.

I have the right to request that CLEARWATER PEDIATRIC CARE restrict how it uses or discloses my child's 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 CLEARWATER PEDIATRIC CARE's use and disclosure of my PHI to carry out TPO. I may revoke my consent in reliance upon my prior consent. If I do not sign this consent, CLEARWATER PEDIATRIC CARE may decline to provide treatment to my child.

______________________________	______________________________
Signature of Legal Guardian	Print Name of Legal Guardian
______________________________	______________________________
Print Name of Patient	Date