Children's Medical Group

Children's Medical Group, P.A.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Children's Medical Group to use and disclose protected health information ("PHI") about my child to carry out treatment, payment and healthcare operations (TPO).

a) **Sharing information for purposes of treatment**: You will share my child's information with all members of their treatment team, both within this office and with other providers (personal and institutional) in order to provide him/her with the quality care the educational/wellness programs specified in his/her insurance plan.

b) **Sharing of information for purposes of payment:** You will share all necessary information with my child's insurer(s), payor(s), governmental entities (such as Medicare, Medicaid, etc.) and their representatives (including, but not limited to, benefit determination and utilization review) as well as your representatives involved in the billing process (including, but not limited to, claims representatives, date warehouses and billing companies.)

c) **Sharing of information for the purposes of operations:** You will share all information necessary for ongoing operations of this office (including, but not limited to, the credentialing process, peer review, accreditation and compliance with all federal and state laws.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Children's Medical Group reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Children's Medical Group's Privacy Officer at 711 W. 39^{8th} Street G-2, Austin, TX 78705.

With this consent, Children's Medical Group may call my home or other alternative 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 calls pertaining to my clinical care, including laboratory results among others.

With this consent, Children's Medical Group may mail to my home or other alternative 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 Personal and Confidential.

I have the right to request that Children's Medical Group 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 form, I am consenting to Children's Medical Group's use and disclosure of my PHI (protected health information) to carry out TPO (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, or later revoke it, Children's Medical Group may decline to provide treatment to me.

_____
Patient's Name

_____ _____ _____
Signature of Patient or Legal Guardian | Print Name of Patient or Legal Guardian | Date