Pediatric Partners, PLC
4649 N Breton Ct SE, Suite A
Kentwood, MI 49508

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Pediatric Partners, PLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Pediatric Partners, 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. Pediatric Partners, PLC 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 Pediatric Partners, PLC's Privacy Officer at 4600 N Breton Ct SE, Suite A, Kentwood, MI 49508

With my consent, Pediatric Partners, 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, school-related issues and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Pediatric Partners, PLC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, school forms and patient statements. With my consent, Pediatric Partners, PLC may e-mail to me appointment reminder cards and patient statements.

I have the right to request that Pediatric Partners, PLC restrict how it uses or discloses my PHI to carry out TPO. See grid below to list designated individuals. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

DESIGNATION OF PERSONS INVOLVED IN CARE
(Parents and Legal Guardians are assumed unless otherwise noted)

NAME	PHONE	RELATIONSHIP TO PATIENT	INITIAL

☐ Check here if using back of page to list more names.

RESTRICTIONS OF PERSONS INVOLVED IN CARE

NAME OF RESTRICTED PERSON	SIGNATURE OF PARENT/LEGAL GUARDIAN

☐ Check here if using back of page to list more names.

By signing this form, I am consenting to Pediatric Partners, PLC's use and disclosure of my 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, Pediatric Partners, PLC may decline to provide treatment to me.

_____
Patient's Name

_____ _____
Signature of Patient or Legal Guardian Date

_____
Print Name of Patient or Legal Guardian