PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION &

RECEIPT OF NOTICE OF PRIVAVY PRACTICIES

I hereby give my consent to Highland Park pediatrics (**central Jersey Pediatrics, PC)** for use and disclose protected health information (PHI) about me/my child (children) to carry out treatment, **payment and health operations (TPO).**

I, _____, Parent of

Have received a copy of **HPP Central Jersey Pediatrics P.C's** Notice of Privacy Practices. I have reviewed the notice of Privacy Practices prior to signing this consent.

Central Jersey Pediatrics, PC Highland Park Pediatrics Reverses the right to revise its Notice of Privacy Practices at anytime. A revised Notice of privacy practice will be posted in waiting room or may be obtained by forwarding a written request to Central Jersey Pediatrics PC.

With this consent **Central Jersey Pediatrics, PC** may call my home or other alternative location and leave a message o 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/my child's (children) clinical care, including laboratory results among them.

With this Consent, **Central Jersey Pediatrics, PC** may mail to my home or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder and patient statements. I have right to request that central Jersey Pediatrics, PC restrict how it uses or discloses my/my child's(children) PHI to carry out TPO.

However, the practice is not required to agree my requested restrictions but if it does it is bound by this agreement.

By signing this form, I am consenting to **Central Jersey Pediatrics, PC** use and disclosure of my/my child's (children) PHI to carry out TPO.

I may revoke my consent in writing except to the extent that practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Central Jersey Pediatrics, PC** may decline to provide treatment to me/my children.

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Patient's Name:
_____

Signature: 1. _____ Name: _____

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