

PERMISSION TO DISCUSS PHI

Patient(s) Name: _____ Date of Birth: _____

Account Number: _____

I hereby give my permission to the person(s) listed below to receive information about the care of the above named patient:

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signature of Patient, Parent, or Guardian

Date

In order to obtain information by telephone, the party calling the practice must share the patient's date of birth with the staff. With the exception of parents or guardians, if the party calling is not on this list, the staff will be unable to share any information regarding the patient.

CONSENT FORM

I understand that as part of my healthcare, Wendover Pediatrics, PA originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. By signing this form, I am consenting to Wendover Pediatrics, PA to use and disclose my health information to carry out my treatment, payment, and healthcare operations (TPO). I also understand this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the many healthcare professionals who contribute to my care;
- A source of information for applying my diagnosis to my bill;
- A means by which a third party payer can verify that services were actually rendered;
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

With this consent Wendover Pediatrics, PA 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 my TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others. With this consent, Wendover Pediatrics, PA may mail to my home or other designated location any items that assist the practice in carrying out TPO.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that the practice reserves the right to change their notice and practices, and prior to implementation, will post a copy of any revised notice in our waiting areas. I also understand that I have the right to restrict as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reliance thereon.

Print Full Name of Patient(s) _____

Patient Date of Birth _____

Signature of Patient or Legal Guardian _____

Date _____