

PEDIATRIC ASSOCIATES OF WINCHESTER

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, **Pediatric Associates of Winchester** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **Pediatric Associates of Winchester'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 Associates of Winchester** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Pediatric Associates of Winchester's** Privacy Officer at 1002 Amherst Street, Building C, Winchester, VA 22601.

With my consent, **Pediatric Associates of Winchester** 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 and any call pertaining to my clinical care, including laboratory results among others.

With my consent, **Pediatric Associates of Winchester** 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 Personal and Confidential.

I have the right to request that **Pediatric Associates of Winchester** 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 **Pediatric Associates of Winchester'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 Associates of Winchester** may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Date

Patient's Name

Print Name of Patient or Legal Guardian