BETHANY PEDIATRICS LLC

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give consent for Bethany Pediatrics and its employees to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

(Bethany Pediatrics Notice of privacy practices provides a more complete description of such uses and disclosure.)
I have the right to review the Notice of Privacy Practices prior to signing this consent this consent.

Bethany Pediatrics 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 Bethany Pediatrics Privacy Officer at 7408 West Chester, Upper Darby, PA 19082.

With this consent , Bethany Pediatrics 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, Bethany Pediatrics may mail to my home or other alternative location any items that may assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential,

With this consent, Bethany Pediatrics e-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. I have the right to request that Bethany Pediatrics 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 to this agreement.

By signing this form, I am consenting to Bethany Pediatric/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, or later revoke it, Bethany pediatrics may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

_____ _____

Patient's Name Date

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Name of Parent or Legal Guardian