PATIENT/PARENT/GUARDIAN CONSENT
FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, WESTSIDE PEDIATRICS, P.A. may use and disclose protected health information (PHI) about _____, hereinafter referred to as "Patient", to carry out treatment, payment, and healthcare operations (TPO). Please refer to WESTSIDE PEDIATRICS 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. WESTSIDE 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:

WESTSIDE PEDIATRICS
20903 Kingsland Blvd
Katy, Texas 77450
Attn: Office Manager

With my consent, WESTSIDE PEDIATRICS may call my home or other designated location and leave a message on voicemail 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 Patient's clinical care including laboratory results among others.

With my consent, WESTISDE PEDIATRICS 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. I have the right to request that WESTSIDE PEDIATRICS restricts how it uses or discloses Patient's protected health information (PHI) to carry out treatment, payment, and healthcare operations (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 WESTSIDE PEDIATRICS' use and disclosure of Patient's 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, WESTSIDE PEDIATRICS may decline to provide treatment to Patient.

_____ _____
Signature of Patient/Parent/Guardian Printed Name of Authorized Signer

_____ _____
Patient's Name Date