



**PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION (PHI)**

I HEREBY GIVE MY CONSENT FOR KIDS KARE PEDIATRICS TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI) ABOUT ME OR MY CHILD TO CARRY OUT TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO). PLEASE REFER TO KIDS KARE’S NOTICE OF PRIVACY PRACTICES FOR 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. KIDS KARE 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 KIDS KARE PRIVACY OFFICER AT 758 SOUTH WILLOW AVENUE, COOKEVILLE TN 38501.

WITH MY CONSENT, KIDS KARE 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 OUR TPO, SUCH AS APPOINTMENT REMINDERS, INSURANCE ITEMS AND ANY CALL PERTAINING TO MY OR MY CHILD’S CLINICAL CARE, INCLUDING LABORATORY TEST RESULTS, AMONG OTHERS.

WITH MY CONSENT, KIDS KARE MAY MAIL OR EMAIL TO MY HOME OR OTHER DESIGNATED LOCATIONS ANY ITEM THAT ASSISTS THE PRACTICE IN CARRYING OUT TPO, SUCH AS APPOINTMENT REMINDER CARDS AND PATIENT STATEMENTS. I HAVE THE RIGHT TO REQUEST THAT KIDS KARE RESTRICT HOW IT USES OR DISCLOSES MY PHI TO CARRY OUT TPO.

BY SIGNING THIS FORM, I AM CONSENTING TO KIDS KARE’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 DOCUMENT, KIDS KARE MAY DECLINE TO PROVIDE TREATMENT TO ME OR MY CHILD.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

TODAY’S DATE

PRINT PATIENT’S NAME

DATE OF BIRTH

PRINTED NAME OF LEGAL GUARDIAN

RELATIONSHIP TO PATIENT