

MOUNTAIN VIEW PEDIATRICS

77 W. Forest, Ste 304 • Flagstaff, AZ 86001

(928) 214-3600

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Mountain View Pediatrics may use and disclose my child's health information to carry out treatment, payment and healthcare operations. Please refer to our office's Notice of Privacy Practices for a more complete description of uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Mountain View Pediatrics reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Mountain View Pediatrics Privacy Officer at 77 W. Forest, Suite 304, Flagstaff, AZ 86001.

With my consent Mountain View Pediatrics 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 regards to my child's healthcare, such as appointment reminders, insurance items and any call pertaining to my child's clinical care, including laboratory results among others.

With my consent, Mountain View Pediatrics may mail to my home or other designated location any items that assist the practice with my child's healthcare, such as appointment reminder cards and patient statements.

With my consent, Mountain View Pediatrics may e-mail to me appointment reminders, patient statements and responses to email I have sent concerning my child's health information.

I have the right to request that Mountain View Pediatrics restrict how it uses or discloses my child's healthcare information to carry out treatment, payment and healthcare operations. 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 Mountain View Pediatrics to use and disclose my child's health information in order to provide treatment, seek payment from insurance companies, other third parties or myself and other items related to health care operations.

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, due to the restrictions on disclosure of healthcare information and its effect on the ability to perform diagnosis and treatment, Mountain View Pediatrics will be unable to provide treatment for my child.

Patient's Name

Parent or Guardian Signature

Date

Print Name of Parent or Legal Guardian