ROSWELL PEDIATRIC CENTER, PC

PATIENT CONSENT FOR USE AND DISCLOSURE

OF PROTECTED HEALTH INFORMATION

With my consent, ROSWELL PEDIATRIC CENTER, PC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to ROSWELL PEDIATRIC CENTER, PC'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. Roswell Pediatric Center, PC 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 Laurie Viebrock, Privacy Officer at 3400 C Old Milton Parkway, Suite 545, Alpharetta, GA 30005.

With my consent, ROSWELL PEDIATRIC CENTER, PC may call my home or other designated location and leave a message on voice mail; with my consent ROSWELL PEDIATRIC CENTER, PC may communicate via fax, secure e-mail, or text message 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 child's or my clinical care, including laboratory results among others. With my consent, ROSWELL PEDIATRIC CENTER, PC 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 ROSWELL PEDIATRIC CENTER, PC restrict how it uses or discloses my PHI to carry out TPO. I do not have to sign this authorization in order to receive treatment from Roswell Pediatric Center, PC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA privacy laws. Roswell Pediatric Center, PC has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at Roswell Pediatric Center, PC.

Patient's Name DOB	Date
Signature of Patient (IF 18 OR OLDER) or Legal Guardian	Print Name of Patient or Legal Guardian