PSOP KIDS
PEDIATRIC SPECIALISTS OF PLANO

Consent for Use and Disclosure of Protected Health Information

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices (NPP). I understand and agree to the following:

Pediatric Specialists of Plano may use and disclose protected health information (PHI) about me and my child to carry out treatment, payment, and healthcare operations as described in our Notice of Privacy Practices.

Pediatric Specialists of Plano may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist in the practice in carrying out treatment, payment, and healthcare operations. This may include appointment reminders, insurance items, laboratory results and any call pertaining to my child's clinical care.

Pediatric Specialists of Plano may email any items that assist in the practice in carrying out treatment, payment, and healthcare operations. This may include appointment reminders, insurance items, laboratory results and any other information pertaining to my child's clinical care.

I have the right to restrict how my child's PHI is used and disclosed and that requests to restrict this information must be submitted in writing. I also understand that Pediatric Specialists of Plano reserves the right to refuse requested restrictions.

Our practice reserves the right to modify the privacy practices outlined in this notice.

This agreement will remain in effect without expiration unless I revoke my consent. I may revoke my consent in writing. I understand that if I revoke my consent that it does not apply to PHI that has already been disclosed for normal agreed upon practice operations. I also understand that if I refuse to sign this consent or if I revoke an already signed consent Pediatric Specialists of Plano will continue to provide treatment to my child.

Your Name (Last, First) | Your Relationship to the Patient

Patient Name (Last, First) | Patient Date of Birth (MM/DD/YYYY)

Signature of Patient / Patient Representative (Required if the patient is a minor or an adult who is unable to sign this form) | Today's Date (MM/DD/YYYY)

I authorize Pediatric Specialists of Plano to release my child's medical records and any information to the following individuals:

1. _____ Relation to the patient: _____
2. _____ Relation to the patient: _____
3. _____ Relation to the patient: _____

Your Name (Last, First) | Your Relationship to the Patient

Patient Name (Last, First) | Patient Date of Birth (MM/DD/YYYY)

Signature of Patient / Patient Representative (Required if the patient is a minor or an adult who is unable to sign this form) | Today's Date (MM/DD/YYYY)