BULLOCH PEDIATRIC GROUP, LLC

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Consent to Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health care, this medical practice originates and maintains health records describing my health history, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality of care.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the practice reserves the right to change their notice of privacy practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the practice is not required to agree to the restrictions requested. I understand and consent to this practice's utilization of a patient notification system to remind patients of upcoming appointments and that this system will contact me via text message, phone call/voicemail or email, whatever my preference may be. I understand that it is my responsibility to update contact phone numbers and/or email addresses to ensure these notifications are delivered to the correct person. I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reliance thereon.

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Patient Name Printed

_____ _____

Parent/Guardian Signature Date

☐ I request the following restrictions to the use or disclosure of my child's health information:

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