

Patient Consent for Use and Disclosure of Protected Health Information

*I hereby give my consent for Lilac City Pediatrics to use and disclose Protected Health Information (PHI) about me (or my minor children) to carry out treatment, payment and healthcare operations (TPO). [Lilac City Pediatrics' Notice of Privacy Practices provides 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. Lilac City Pediatrics 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 Lilac City Pediatrics' Privacy Officer at 180 Farmington Road, Rochester, NH 03867.*

*With this consent, Lilac City Pediatrics may call my home or alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.*

*With this consent, Lilac City Pediatrics may mail to my home or alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. With this consent, Lilac City Pediatrics may e-mail to my home or alternative location any items that assist the practice in carrying out TPO.*

*I have the right to request that Lilac City Pediatrics restrict how it uses or discloses my PHI to carry out TPO. 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 Lilac City Pediatrics' 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 consent, or later revoke it, Lilac City Pediatrics may decline to provide treatment to me or my minor children.*

\_\_\_\_\_  
SIGNATURE OF PERSON FILLING OUT FORM

\_\_\_\_\_  
PATIENT S NAME

\_\_\_\_\_  
DATE

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Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, \_\_\_\_\_, have received a copy of  
Lilac City Pediatrics' Notice of Privacy Practices on behalf of my child.

\_\_\_\_\_  
SIGNATURE OF PERSON FILLING OUT FORM

\_\_\_\_\_  
PATIENT S NAME

\_\_\_\_\_  
DATE