# NORTHEAST PEDIATRICS
# AUTHORIZATION AND PRIVACY POLICIES

**Patient Name**_____ **Date of Birth**_____

## PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

**I _____ have reviewed a copy of NORTHEAST PEDIATRICS notice of privacy polices.**

With my consent, NORTHEAST PEDIATRICS may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations (TPO). I have the right to receive a copy of "Notice of Privacy Practices" prior to signing this consent. NORTHEAST PEDIATRICS reserves the right to revise the Notice of Privacy Practices at anytime. If revised, a copy of the new Notice of Privacy Practices will be posted on the office bulletin board and a copy of the same may be obtained by forwarding a written request to:

Northeast Pediatrics
431 Southwest Blvd. N
St. Petersburg, Florida 33703

With my consent, NORTHEAST PEDIATRICS may call my home or other designated location and leave a message on the voicemail 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 clinical care, including laboratory results among others.

I have the right to request that NORTHEAST PEDIATRICS restrict how it uses or discloses my Protected Health Information to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if does, it is bound by this agreement.

By signing this form, I am consenting to NORTHEAST PEDIATRICS use and disclosure of my Protected Health Information 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 prior consent. If I do not sign this consent, NORTHEAST PEDIATRICS may decline to provide treatment to me.

_____ _____ _____
Signature of Parent/Legal Guardian Date Printed Name

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## PERMISSION TO SEEK MEDICAL CARE FOR MY CHILD IN MY ABSENCE:

I hereby request and give permission to the physician of NORTHEAST PEDIATRICS to provide such medical examination and treatment as she deems best for my child's physical and mental well being. I understand that I am responsible for following up on diagnostic tests and future appointments.

I _____, give my permission to _____ _____
Parent or Guardian Friend, Relative, or Specify Phone Number
to seek medical treatment for my child _____.
Childs Name

_____ _____
Parent or Guardian Signature Date