

CHILDREN'S MEDICAL CLINICS OF EAST TEXAS

1011 W. Grove
Kaufman, Texas 75142
972-932-1319

Patient Consent For Use And Disclosure Of Protected Health Information

With my consent, **Children's Medical Clinics of East Texas** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **Children's Medical Clinics of East Texas** Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review your Notice of Privacy Practices prior to signing this consent. **Children's Medical Clinics of East Texas** reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our Privacy Officer at 1011 West Grove, Kaufman, Texas 75142.

With my consent, **Children's Medical Clinics of East Texas** may call my home or office 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 call pertaining to your clinical care, including laboratory results among others.

With my consent, **Children's Medical Clinics of East Texas** may mail to my ___ home or ___ office any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements.

With my consent, **Children's Medical Clinics of East Texas** may e-mail to my ___ home or ___ office 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 **Children's Medical Clinics of East Texas** restrict how **Children's Medical Clinics of East Texas** uses or discloses my PHI to carry out TPO. However, **Children's Medical Clinics of East Texas** is not required to agree to my requested restrictions, but if **Children's Medical Clinics of East Texas** does, they are bound by our agreement.

By signing this form, I am consenting to **Children's Medical Clinics of East Texas'** use and disclosure of my PHI to carry out TPO. This consent may be revoked in writing except to the extent that **Children's Medical Clinics of East Texas** has already made disclosures in reliance upon my consent. If I decline to sign this consent, **Children's Medical Clinics of East Texas** may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name

Print Name of Patient or Legal Guardian

Date