CHILDREN'S MEDICAL GROUP, LTD
6780 W. THUNDERBIRD RD., STE A101
PEORIA, ARIZONA 85381
(602) 843-1991 FAX (602) 843-3224

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Children's Medical Group, Ltd. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). This consent includes other healthcare providers, such as specialists / consultants, laboratories. Please refer to Children's Medical Group, Ltd. Notice of Privacy Practices for 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. Children's Medical Group, Ltd. 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 Children's Medical Group, Ltd. Privacy Officer at 6780 W. Thunderbird Rd., Suite A-101, Peoria, AZ 85381, 602-843-1991.

With my consent, Children's Medical Group, Ltd. may call my home or other designated 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 call pertaining to my clinical care, including, when necessary, laboratory results among others.

With my consent, Children's Medical Group, Ltd. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as patient statements. Children's Medical Group, Ltd. reserves the right to add e-mail to its TPO in the future.

I have the right to request that Children's Medical Group, Ltd. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my restrictions, but if it does, It is bound by this agreement.

By signing this form, I am consenting to Children's Medical Group, Ltd. 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, Children's Medical Group, Ltd. may decline to provide treatment to me.

_____		_____
Print Patient Name	Date of Birth	Today's Date

_____	_____
Print Name of Parent / Legal Guardian	Signature of Parent / Legal Guardian