Pediatric Partners of Jeffersontown, PLLC

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Patient Consent: For use and disclosure of protected health information

- I hereby acknowledge that I have received and had an opportunity to ask questions regarding the Notice of Privacy Practices for Pediatric Partners of Jeffersontown.

- I consent that Pediatric Partners of Jeffersontown may use and disclose protected health information about myself and/or my child to carry out treatment, payment and health operations (TPO).

- I consent that, Pediatric Partners of Jeffersontown 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 clinical care- including lab results. In addition, I permit communications related to TPO to be mailed to my home or other designated location.

- I further consent, that with my verbal request and permission, Pediatric Partners of Jeffersontown may provide routine written or faxed copies of immunizations, camps and athletic leagues.

Patient Name: _____

Signature of Patient or Patient's Guardian: Date Signed:

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