



Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Integrative Pediatrics, Inc. may use and disclose protected health information (PHI) about my child to carry out treatment, payment and health care operations (TPO). Please refer to Integrative Pediatrics, Inc. Notice of Privacy Practices for a more complete description of such uses and disclosures. This information is posted in the waiting room area and copies are available.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Integrative Pediatrics, Inc. 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 Dr. Lisa R. Ramey's office.

With my consent, Integrative Pediatrics, Inc. 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 issues and any call pertaining to my child clinical care, including laboratory results among others.

With my consent, Integrative Pediatrics, Inc. may mail to my home or other designated location 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 Integrative Pediatrics, Inc. restrict how it uses or disclose my child Protected Health Information to carry out treatment, payment and healthcare operations (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 Integrative Pediatrics, Inc. use and disclosure of my child's 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, Integrative Pediatrics, Inc. may decline to provide treatment to my child.

I further acknowledge receipt of the Integrative Pediatrics, Inc. Privacy Statement.

Signature of Parent/Guardian

Patient Name

Print name of Parent/Guardian

Date: _____