PEDIATRIC ASSOCIATES AT ARGYLE, P.A.

8351 Westport Road Jacksonville, FL 32244
Tel. 904-317-8811 Fax 904-317-4949

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Pediatric Associates at Argyle, PA may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Pediatric Associates at Argyle, PA's 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. Pediatric Associates at Argyle, PA 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 Pediatric Associates at Argyle, PA Privacy Officer at 8351 Westport Road, Jacksonville, Florida 32244.

With my consent, Pediatric Associates at Argyle, PA may call my home or other designated location and leave a message on voice mail, answering machine 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 laboratory results among others.

With my consent, Pediatric Associates at Argyle, PA 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 as long as they are marked Confidential.

With my consent, Pediatric Associates at Argyle, PA may e-mail to me my appointment reminder cards and patient statements. I have the right to request that Pediatric Associates at Argyle, PA restrict how it uses or discloses my PHI to carry out 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 Pediatric Associates at Argyle, PA's 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, Pediatric Associates at Argyle, PA may decline to provide treatment to me.

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Signature of Patient or Legal Guardian | Print Name of Patient or Legal Guardian

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Patient's Name | Date