

# Hilliard Pediatrics, Inc.

## Patient Consent for Use and Disclosure of Protected Health Information

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

At Hilliard Pediatrics, Inc. we are committed to protecting the security and privacy of your child's personal information. Medical records are the property of Hilliard Pediatrics, Inc., kept in a secure location, and are accessed for only purposes outlined by the Notice of Privacy Practices. Records may be released or shared with other health care providers for treatment of your child.

With my consent, Hilliard Pediatrics, Inc. may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Hilliard Pediatrics, Inc.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to, and have been given the opportunity to, review the Notice of Privacy Practices prior to signing this consent. Hilliard Pediatrics, Inc. 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 Hilliard Pediatrics, Inc. Privacy Officer at 3855 Trueman Court Hilliard, Ohio 43026 or by going to [www.hilliardpeds.com](http://www.hilliardpeds.com).

I understand that Hilliard Pediatrics, Inc., its attorney, and/or its agents, including collection agencies may call my home, cell phone, and place of employment for healthcare reasons, appointment reminders and to resolve billing issues. Hilliard 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 items and any call pertaining to my clinical care, including laboratory results among others.

Hilliard 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 and that appointment reminders may be sent via postcards.

It is our office policy NOT to fax Medical Information except to another medical provider.

I understand that Hilliard Pediatrics, Inc. may discuss protected health information with adults or other minors present during the visit. It is the responsibility of the patient and/or guardian to indicate otherwise during each visit.

Hilliard Pediatrics, Inc. participates in an organized healthcare arrangement through OhioHealth Group, Ltd. (OhioHealth Group). OhioHealth Group consists of an organized system of healthcare in which multiple covered entities participate. Through OhioHealth Group, we participate in joint activities that include utilization review, quality assessment and improvement activities, and certain payment activities. We may disclose your PHI to other participants in this organized healthcare arrangement in order to facilitate the healthcare operations activities of OhioHealth Group.

I have the right to request that Hilliard Pediatrics, Inc. restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Hilliard Pediatrics, Inc.'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, Hilliard Pediatrics, Inc. may decline to provide treatment to me.

**I understand and agree to all of the above unless I strike through one of the statements.**

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date