Town & Country Pediatrics, PC
Care of Infants, Children, and Adolescents
3009 N. Ballas, Suite 141A
Town & Country, MO 63131
Office 314-994-0209
Fax 314-994-9130

Due to the federal privacy regulations, we cannot leave messages with protected health information on home answering machines or with family members without written permission.

Patient(s) name _____

_____

_____

_____

_____

_____

I give **Town & Country Pediatrics, PC** permission to leave messages

_____ On my home answering machine/voice mail.

_____ On my work answering machine/voice mail.

_____ On my cell phone voice mail.

_____ With the persons listed (name and relationship).

_____

_____

_____
Signature

_____ I do not want medical information released except personally to myself.

_____
Signature

Town & Country Pediatrics, PC

OPEN AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Please list ALL children (under 18) we will be caring for

PATIENT NAME(S)	Date of Birth

I, _____ hereby authorize **Town & Country Pediatrics, PC** to release any and all Protected Health Information (PHI) maintained in my child's Medical Record to the following individuals, concerning my child's status as a patient, treatment or payment of services provided by **Town & Country Pediatrics, PC**.

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

This authorization is given freely with the understanding that:

1. This authorization is valid until revoked by me.
2. I may revoke this authorization at any time, except where information has already been released, by completing Town & Country Pediatrics, PC's Revocation of Authorization Form.
3. Individuals listed on this form will be able to receive any and all information related to my status as a patient, treatment or payment of services provided to me by Town & Country Pediatrics, PC during the time period in which this authorization is valid.
4. Individuals not listed above will be unable to receive any information regarding treatment or payment for services provided to my child without my prior written authorization.
5. Town & Country Pediatrics, PC and its workforce members are hereby released form any legal responsibility or liability for disclosure or any of my Protected Health Information as indicated and authorized herein.

_____ _____

Parent's signature (or personal representative) Date

_____ _____

Relationship to Patient Witness

For Office Use Only

Date of Receipt		Signature	

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CONSENT FORM

I understand as part of my healthcare, Town & Country Pediatrics, PC originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plan for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the many health professionals who contribute to my care;
- A source of information for applying my diagnosis and health information for billing purposes;
- A means by which a third-party payer can verify that services billed were actually provided;
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have received the Town & Country Pediatrics, PC's *Notice of Privacy Practices*, which provides a more complete description of information uses and disclosures. I have the right to review this notice prior to signing this consent. I understand the organization reserves the right to change their notice and practices at any time and I may request a copy of any revised notice by contacting Town & Country Pediatrics, PC's Privacy Officer at (314) 994-0209.

I understand I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this organization is not required to agree to the restrictions requested. I understand I may revoke this consent by contacting Town & Country Pediatrics, PC's Privacy Officer and requesting a Revocation of Consent Form. I understand revoking my consent does not affect disclosures already make in reliance of my prior consent.

This consent is given freely with the understanding that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as authorized by law. A photocopy or fax of this consent is as valid as the original.

_____ _____

Print Parent's Name Date

_____

Parent's Signature (or personal representative)

_____ _____

Witness Date

NOTICE OF PRIVACY PRACTICES

Acknowledgement

I acknowledge that I have received a summary of Town & Country Pediatrics, PC's Notice of Privacy Practices and consent to the use or disclosure of my protected health information by Town & Country Pediatrics, PC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, to conduct health care operations of Town & Country Pediatrics, PC, and as required by law.

I also acknowledge that I was offered the entire notice and that I understand I may obtain a full version of the notice at any time. I understand my rights as a patient of this practice concerning my Protected Health Information (PHI), as it is outlined in this notice. I am aware Town & Country Pediatrics, PC reserves the right to change the privacy practices that are described in this Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by contacting the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

_____

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_____

_____

_____

Name of Patient(s)

_____

Signature of Patient or Personal Representative

_____

Relationship to Patient

_____

Date