

NORTHERN KENTUCKY PEDIATRIC GROUP, PSC

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, **N . K . P . G .**
Practice Name may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **N . K . P . G .**
Practice Name'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.

 N . K . P . G .
Practice Name 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 **N . K . P . G .**
Practice Name Privacy Officer at [*Street Address, City, State Zip*].

**1805 Alexandria Pike
Highland heights, ky 41076**

With my consent, **N . K . P . G .**
Practice Name 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.

With my consent, **N . K . P . G .**
Practice Name 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 Personal and Confidential.

With my consent, **N . K . P . G .**
Practice Name may e-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

 N . K . P . G .
Practice Name 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 **N.K.P.G.** 's use and disclosure of my PHI
Practice Name
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,

 N.K.P.G. may decline to provide treatment to me.
Practice Name

Signature Of Patient Or Legal Guardian

Patient's Name

Date

Print name of Patient or Legal Guardian

NORTHERN KENTUCKY PEDIATRIC GROUP

DATE: _____

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE PRIVACY PRACTICES OF NORTHERN KENTUCKY PEDIATRIC GROUP.

PRINT PATIENT'S NAME: _____

SIGNATURE OF PATIENT OR GUARDIAN: _____