



PROTECTED HEALTH INFORMATION (PHI) CONSENT FORM

A. CHECK THE BOX THAT APPLIES

- I am the patient
 The patient is a minor

B. PLEASE READ

I understand that as part of my child's health care, Mercy Children's Clinic originates and maintains health records. These records describe history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Health Information Practices that describes uses and disclosures of my child's Protected Health Information (medical record). I understand that I have the right to review the notice prior to signing this consent.

With my consent, Mercy Children's Clinic may call (including leaving voice mail messages), mail, or e-mail my home regarding items that assist the practice in carrying out treatment, payment, and health care operations, such as appointment reminders, laboratory results, and insurance items.

I understand that Mercy Children's Clinic has the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address that I have provided.

I understand that I have the right to request restrictions as to how my child's health information may be used or disclosed to carry out treatment, payment, or health care operations and that Mercy Children's Clinic is not required to agree to the restrictions requested.

I understand that I may revoke this consent in writing, except to the extent that Mercy Children's Clinic has already taken action. If I do not sign this consent or revoke it, Mercy Children's Clinic may decline to provide treatment to my child.

I fully understand and I consent to Mercy Children's Clinic use and disclosure of my child's Protected Health Information to carry out treatment, payment, and health care operations.

C. PLEASE FILL OUT

Signature

Date

Print Name

Relationship (if patient is a minor) Father / Mother Grandparent Guardian Other: