Consent Form

I consent to the use or disclosure of my protected health information by **Pediatric Associates of West Tennessee, PLLC** for the purpose of diagnosing or providing treatment, obtaining payment for my health care bills or to conduct health care operations of **Pediatric Associates of West Tennessee, PLLC.** I understand that diagnosis or treatment of my child by **Pediatric Associates of West Tennessee, PLLC**, may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Pediatric Associates of West Tennessee, PLLC** is not required to agree to the restrictions that I may request. However, if **Pediatric Associates of West Tennessee, PLLC** agrees to a restriction that I request, the restriction is binding on **Pediatric Associates of West Tennessee, PLLC** and Jamie Ellerbrook, MSN, APRN, NP-C, CLC.

I have the right to revoke this consent, in writing, at any time, except to the extent **that Pediatric Associates of West Tennessee, PLLC** or Jamie Ellerbrook, MSN, APRN, NP-C, CLC, has taken action in reliance on this consent.

My protected health information means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review **Pediatric Associates of West Tennessee, PLLC**'s Notice of Privacy Practices prior to signing this document. **Pediatric Associates of West Tennessee, PLLC** Notice of Privacy Practices has been provided to me. The notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Pediatric Associates of West Tennessee, PLLC** The Notice of Privacy Practices for **Pediatric Associates of West Tennessee, PLLC** is also posted in the waiting area, the well-baby waiting area and in each patient room. The Notice of Privacy Practices also describes my rights and **Pediatric Associates of West Tennessee, PLLC's** duties with respect to my protected health information.

Pediatric Associates of Tennessee, PLLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy being sent in the mail or asking for one at the time of my next appointment.

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Print Name and Date of Birth of Child

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Print Name of Parent/Guardian

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Signature of Patient & Today's Date

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Today's Date