Children's Medical Group of Austin, PLLC
Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for CMG to use and disclose protected health information (PHI) about my child to carry out treatment, payment, and healthcare operations.

A) Sharing information for purposes of treatment: You will share your child's information with all members of their treatment team, both within this office and with other providers (personal and institutional) to provide him/her with the quality care the educational/wellness programs specified in his/her insurance plan.

B) Sharing information for purposes of payment: You will share all necessary information with my child's insure(s) and payor(s), governmental entities (such as Medicare/Medicaid) and their representatives (including but not limited to, benefit determination and utilization review) as well as your representative involved in the billing process (including but not limited to, claims representatives, data warehouse, and billing companies.

C) Sharing information for the purposes of operations: You will share all information necessary for ongoing operations of this office (including but not limited to, the credentialing process, peer review, accreditation, and compliance with all federal and state laws.)

I have the right to review the Notice of Privacy Practices before signing this consent form. Children's Medical Group reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained forwarding a written request to our address: 631 W 38th St. Ste 3. Austin, TX 78705.

With this consent, Children's Medical Group may call my home or other alternative location and leave a message on voicemail or in person. Some of that information may consist of appointment reminders, insurance items or any call pertaining to clinical care.

With this consent, Children's Medical Group may mail to my home or other alternative location any items that assist the practice in carrying out TPO (Treatment, Payment, and Healthcare operations), such as patient statements or other notice and communication.

I have the right to request that Children's Medical Group 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 agreement, I am consenting to Children's Medical Group's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except if the practice has already made disclosures in reliance on my prior consent. If I do not sign this consent, or later revoke it, Children's Medical Group may decline to provide treatment to my child.

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Patient's Name **Date of Birth**

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Signature of Parent/Guardian **Date**