

OLENTANGY PEDIATRICS, INC.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Olentangy Pediatrics, Inc., to use and disclose protects health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Olentangy Pediatrics, Inc.'s Notice of Privacy Practices provides 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.

Olentangy Pediatrics, Inc. 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: Olentangy Pediatrics, Inc., Privacy Officer at 4775 Knightsbridge Blvd., Ste 207, Columbus, Ohio 43214.

With this consent, Olentangy Pediatrics, Inc. may call my home or other alternate 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 clinical care, including laboratory results among others.

With this consent, Olentangy Pediatrics, Inc. may mail to my home or other alternate location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Olentangy Pediatrics, Inc may e-mail to my home or other alternative 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 Olentangy Pediatrics, Inc. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Olentangy Pediatrics, Inc.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made the disclosures in reliance upon my prior consent. If I do not sign this consent, or later I revoke it, Olentangy Pediatrics, Inc may decline to provide treatment to me.

Patient(s) Name(s)

Chart #

Printed Name Patient/Legal Guardian

Signature of Patient/Legal Guardian

Date