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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Pediatric Care of Lansing may use and disclose protected health information (PHI) about my child to carry out treatment, payment and healthcare operations (TPO). Please refer to Pediatric Care of Lansing'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. Pediatric Care of Lansing reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Pediatric Care of Lansing at 307 W. Lake Lansing Road, East Lansing, Michigan 48823.

With my consent, Pediatric Care of Lansing may call my home or other designated location, leave a message on voice mail or in person, and fax information 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, Pediatric Care of Lansing may mail to my home or other designated location any item 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, Pediatric Care of Lansing may share information with other medical personnel.

By signing this form, I am consenting to Pediatric Care of Lansing's use and disclosure in reliance upon my prior consent. If I do not sign this consent, Pediatric Care of Lansing may decline to provide treatment to me.

Print Name of Legal Guardian/Patient (IF 18 OR OLDER)

Signature of Legal Guardian/Patient (IF 18 OR OLDER)

Print All Children's Names (IF UNDER 18)

Date

PATIENT PRIVACY QUESTIONNAIRE:

- I. **FOR MINORS ONLY:** Please **list** the **family members (PLEASE INCLUDE THEIR RELATIONSHIP TO PATIENT)** or other **persons**, if any, who have your **permission to bring** your child for treatment to Pediatric Care of Lansing, P.C. If none, please indicate below:

- II. Please **list** the **family members** or other **persons**, if any, whom we may **inform** about your child's/your own (if 18 or older) general medical condition and diagnosis (including treatment, payment, and health care operations). If none, please indicate below:

