



Children's Health of Carolina, PA  
HIPAA Consent Form

I understand that as part of my healthcare, Children's Health of Carolina, PA (d.b.a. Cumberland Children's Clinic, Lumberton Children's Clinic, Pembroke Pediatrics and Raeford Pediatrics) originates and maintains health records describing my child's/children's health history, symptoms, examination, test results, diagnoses and treatment plans (including referrals and future appointments). By signing this form, I am consenting to Children's Health of Carolina, PA to use and disclose me child's/children's health information to carry out treatment, payment and healthcare operations (TPO). I further understand this information serves as:

- A basis for planning my child's/children's care and treatment;
- A means of communication among the many healthcare professionals who contribute to my child's/children's care;
- A source of information for applying my child's/children's diagnoses to a bill;
- A means by which a third party payer can verify that services were actually provided;
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professions.

With this consent, Children's Health of Carolina, PA may call my home or other designated locations provided by me as a legal guardian and leave a message on voice mail or in person; FAX, or email me in reference to any items that assist the practice in carrying out my child's/children's TPO.

I understand and have been provided an opportunity to review the corporate HIPAA notice. I further understand that the corporation reserves the right to change the notice at any time, with the changes being posted in our reception areas. I also understand that I have the right to modify or revoke this consent form at any time, except to the extent that Children's Health of Carolina, PA has already taken action in reliance thereon.

I authorize Children's Health of Carolina, PA to communicate my child's/children's protected information in the following methods:

- Leave a detailed message(s) on my home telephone answering machine.
- Leave a detailed message(s) on my office telephone answering machine.
- Leave a detailed message(s) on my cell phone answering machine.
- Leave a detailed message(s) on my FAX.
- Email detailed medical information.

I hereby give permission to the following person(s) listed below to receive information about the care of my child/children:

Name

Relationship

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In order to obtain information by telephone, the party called must provide the practice with the patient's date of birth. With the exception of parents or legal guardians, if the party is not on the list, the staff will be unable to share any information regarding the patient.

\_\_\_\_\_  
Print full name of child

\_\_\_\_\_  
Child's date of birth

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Print full name of child

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Child's date of birth

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Print full name of child

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Child's date of birth

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Child's date of birth

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Print full name of child

\_\_\_\_\_  
Child's date of birth

I have read, understand and agree with the terms of this consent. I further acknowledge that I can legally represent the child/children listed on the document.

\_\_\_\_\_  
Printed name of parent/legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent/legal guardian