Blue Sky Pediatrics
Asheville

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With the following consent, Blue Sky Pediatrics Asheville PA may use and disclose protected health information (PHI) about (child's name)_____to carry out treatment, payment and healthcare operations (TPO). Please refer to Blue Sky Pediatrics Asheville PA's Notice of Privacy Practices for a more complete description of such uses and disclosure.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Blue Sky Pediatrics Asheville PA reserves the right to revise its Notice of Privacy Practice at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Privacy Officer
Blue Sky Pediatrics Asheville PA
5 Walden Ridge Drive
Asheville, NC 28803

With my following consent, Blue Sky Pediatrics Asheville PA may call my home or other designated 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 my child's clinical care, including laboratory results among others.

With my following consent, Blue Sky Pediatrics Asheville PA may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my following consent, Blue Sky Pediatrics Asheville PA may email to me appointment reminders and patient statements. I have the right to request that Blue Sky Pediatrics Asheville PA restrict how it uses or discloses my child's PHI to carry out TPO. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Blue Sky Pediatrics Asheville PA's use and disclosure of my child's PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Blue Sky Pediatrics Asheville PA may decline to provide treatment to my child.

_____ _____
Signature of Parent or Legal Guardian Patient's Full Name

_____ _____
Print Name of Parent or Legal Guardian Patient's Date of Birth

_____
Date of Signature