PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Pediatric Gastroenterology of Charleston (PGC) to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). PGC'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.

PGC reserves the right to revise its Notice of Privacy Practices at any time. A copy of Notice of Privacy Practices may be obtained by forwarding a written request to Pediatric Gastroenterology of Charleston Privacy Officer at 428 Division street, Suite#3A, Charleston WV 25309 and is available on the web site for the practice.

With this consent, PGC may call my home, or other alternative location or email 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 calls pertaining to my clinical care, including laboratory results among others.

With this consent, PGC may 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.

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By signing this form, I am consenting to PGC'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 disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, PGC may decline to provide treatment to me.

_____ _____

Signature of Patient/ Parent or Legal Guardian Date

_____

Printed Name of Patient/ Parent or Legal Guardian

_____

Name of Child(ren)