FOSTER CITY PEDIATRIC MEDICAL GROUP, INC.
Patient Consent Form

I understand that as part of my child's health care, Foster City Pediatric Medical Group, Inc. maintains health records that include his/her health history, symptoms, examination and test results, diagnoses and treatment and any plans for future treatment.

I understand that this information is used

- As a basis for planning my child's care and treatment.
- As a means of communicating among other health care professionals who contribute to my child's care.
- As a source of information necessary for billing purposes.
- As a means by which a third-party payor can verify that services billed were actually provided.
- As a tool for routine health care operations such as assessing care quality.

With this consent, Foster City Pediatric Medical Group, Inc. may

- Call my home or other location that I specify and leave a message regarding appointment reminders, insurance items and any calls pertaining to my child's clinical care, including lab and x-ray results.
- Mail to my home or other location that I specify patient statements, referrals or prescriptions that are needed to carry out health care operations.
- Use and/or disclose certain protected health information (PHI) about my child for schools, camps or sports on a form that I submit for completion.
- Use and/or disclose my child's PHI to insurance companies for under-writing purposes provided signed release is attached.
- Provide immunization records by fax or mail to a location specified at my request.

I understand that I have the right

- To request restrictions as to how my child's health information may be used or disclosed to carry out treatment, payment or health care operations and that the practice is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the practice has already made disclosure in reliance upon my prior consent. My written revocation must be submitted to the Privacy Officer at: 1295 E. Hillsdale Foster City, CA 94404

Signature of Parent or Legal Guardian_____

Patient Name_____ _____

_____ _____

Date_____