PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION & RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby give my consent to **The Medical Group of New Jersey (MGNJ) HNR Pediatrics LLC** (formerly Central Jersey Pediatrics and New Brunswick Pediatric Group) for use and disclosure of protected health information (PHI) about me/my child (children) to carry out **treatment, payment and health operations (TPO)**.

I, _____, parent/guardian of _____
(Parent/Guardian) *(Patient(s))*

Have received a copy of MGNJ HNR Pediatrics **Notice of Privacy Practices**. I have reviewed the notice of Privacy Practices prior to signing this consent.

The Medical Group of New Jersey HNR Pediatrics reserves the right to revise it's Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices will be posted in the waiting room or may be obtained by forwarding a written request to HNR Pediatrics.

With this consent, HNR Pediatrics may speak in-person, or call my home or other alternative location and leave a message or voicemail in reference to any items that assist the practice of carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to me/my child's (childrens') clinical care, including laboratory results among them.

With this consent, HNR Pediatrics may mail to my home or other alternative locations any items that assist in the practice of carrying out TPO, such as appointment reminders and patient statements.

I have the right to request that HNR Pediatrics restrict how it uses or discloses my/my child's (childrens') PHI to carry out TPO. I understand this practice is not required to agree to my requested restrictions, however, if it does agree, then it is bound by this agreement.

By signing this form, I am consenting to HNR Pediatrics use and disclosure of my/my child's (childrens') 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, HNR Pediatrics may decline to provide treatment to me/my children, except in the case of emergency.

Patient's Name: _____

Parent/Guardian Signature:_____ Date: _____