AUTHORIZATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

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My child's/children's "Protected Health Information" means health information, including my child's/children's demographic information, collected from my child/children and created or received by their physician, another healthcare provider, a health plan, their employer or a health care clearinghouse. This protected health information related to my child's/children's past, present, or future physical or mental health or condition and identifies my child/children, or there is a reasonable basis to believe the information may identify my child/children.

I consent to the use or disclosure of my child's/children's protected health information by Bright Future Pediatrics, LLC for the purpose of diagnosing or providing treatment to my child/children, for the purpose of obtaining payment for my child's/children's healthcare bills, or to conduct healthcare operations at Bright Future Pediatrics, LLC.

I understand that diagnosis or treatment by Bright Future Pediatrics, LLC may be conditional upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my child's/children's "Protected Health Information" is used or disclosed to carry out treatment, payment or health care operations of the Bright Future Pediatrics, LLC. Bright Future Pediatrics, LLC is not required to agree to the restrictions that I may request. However, if Bright Future Pediatrics, LLC agrees to a restriction that I request, the restriction is binding on Bright Future Pediatrics, LLC.

I understand that I have a right to review the Bright Future Pediatrics, LLC Notice of Privacy Practices, which was provided to me, prior to signing this document. I understand the latest version of the Notice will be posted in the office of Bright Future Pediatrics, LLC and is also available for review via their website at www.brightfuturepediatrics.com. I may obtain any revised Notice of Privacy Practices by contacting the practice office and requesting a paper or electronic copy be provided to me.

I have received and read a copy of the Bright Future Pediatrics, LLC Financial & Office Policy.

I permit a copy of this authorization to be used in place of the original.

I authorize Bright Future Pediatrics, LLC (BFP) to use the channels detailed below for communicating information related to my child's/children's personal health, treatment or payment for treatment. This request supercedes any prior request for confidential channel communications I have made.

Please check-mark all acceptable communication methods that apply. Please place a star next to the method you most prefer.

☐ **PHONE** - I authorize BFP to contact me at the following phone number(s):

Home _____

Cell _____

Work _____

☐ **MAIL** - I authorize BFP to contact me by mail, using the following address: _____

_____

☐ **EMAIL** - I authorize BFP to contact me by email which may include the transmission of personal health information, using the following email address: _____

☐ **FAX** - I Authorize BFP to contact me by fax, using the following number: _____

☐ **OTHER METHOD:** _____

PREFERRED PHARMACY *(This is the pharmacy BFP will use for prescriptions unless you notify BFP otherwise.)*

I authorize BFP to speak to my preferred pharmacy detailed below regarding any prescriptions provided by BFP:

Pharmacy Name _____ Phone: _____

Address _____

I understand that I have the right to revoke this consent, in writing, at any time, except to the extent Bright Future Pediatrics, LLC has take action in reliance on this consent.

Patient Name(s):

_____ **Signature of Parent/Legal Guardian** ***WRITTEN SIGNATURE ONLY***

_____

_____ **Print Name of Parent/Legal Guardian** _____

_____

_____ **Date** _____