Royale Pediatric Healthcare, PC
R. Francisque-St. Victor, M.D.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Dr. Rosemarie Francisque-St. Victor** to use and disclose protected health information (PHI) about me to carry out treatment Payment and health care operations (TPO).

*The notice of Privacy Practices provided by **Royale Pediatric Healthcare, PC** describes such uses and disclosures more completely.*

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Royale Pediatric Healthcare, PC** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practives may be obtained by forwarding a written request to **R. Francisque-St. Victor, M.D**.

With this consent, **Royale Pediatric Healthcare, PC** may call my home or other alternative location and leave a message on voicemail 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 test results, among others.

With this consent **Royale Pediatric Healthcare, PC** may e-mail my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that **Royale Pediatric Healthcare, PC** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this for, I am consenting to allow **Royale Pediatric Healthcare, PC** to use and disclose 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, **Royale Pediatric Healthcare, PC** may decline to provide treatment to me.

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Signature of Patient/Legal Guardian

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Print Patient's Name Date

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Print Name of Legal Guardian (if applicable)

Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

- ☐ **Home Phone**
  - Leave message with detailed information
  - Leave message with call back number only
- ☐ **Cell Phone**
  - Leave message with detailed information
  - Leave message with call back number only
- ☐ **Work Phone**
  - Leave message with detailed information
  - Leave message with call back number only
- ☐ **Written Communication**
  - Send mail to my home address
  - Send mail to my work address
  - Send fax correspondence to _______________

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for *TPO* may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom (Address of Fax)	Description of Disclosure/Purpose of Disclosure	By Whom Disclosed

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Signature of Patient/Legal Guardian

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Print Patient's Name

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Date

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Print Name of Legal Guardian (if applicable)