

**PATIENT CONSENT  
FOR USE & DISCLOSURE OF  
PROTECTED HEALTH INFORMATION**



Kids First Pediatric Partners  
Concourse Office Plaza, Tower 2  
4709 Golf Rd., Ste. 900  
Skokie, IL 60076  
Phone: 847.676.5394 Fax 847.679.7183  
[www.kidsfirstpediatricpartners.com](http://www.kidsfirstpediatricpartners.com)

With my consent, Kids First Pediatric Partners ("the practice") may use and disclose Protected Health Information (PHI) about my child to carry out treatment, payment and healthcare operations (TPO). Please refer to our Notice of Privacy Practices for 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.

Kids First Pediatrics reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Policies may be obtained by forwarding a written request to our office at 4709 Golf Road, Suite # 900, Skokie, Illinois 60076, (847) 676-5394.

With my consent Kids First Pediatrics may call my home or other designated location and leave a message on voice mail in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my child's clinical care, including laboratory results among others.

With my consent, Kids First Pediatrics may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request in writing that the practice restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it's bound by this agreement.

By signing this consent form, I am consenting to the practice'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, the practice may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date