PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Child Neurology of SLO
Debra L. Balke, M.D.
Diplomate, American Board of Psychiatry and Neurology
1320 Las Tablas Road, Suite E
Templeton, CA 93465
Office: (805) 434-0960 Fax: (805) 434-0978

Concerning:
(Patient's Name)

DOB:

I hereby give my consent for the office of **Debra L. Balke, M.D.** to use and disclose protected health information (PHI) about the above-named person to carry out treatment, payment, and healthcare operations (TPO). (Please refer to **Debra L. Balke, M.D.'s** 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.

Debra L. Balke, M.D. reserves the right to revise its Notices of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Debra L. Balke, M.D. Privacy Officer at 1320 Las Tablas Rd., Suite E, Templeton, CA 93465**

With this consent, the office of **Debra L Balke, M.D.** may call my home or other alternative locations and leave messages 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 the above-named person's clinical care, including laboratory results among others.

With this consent, the office of **Debra L. Balke, M.D.** may mail to my home or other alternative locations any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements.

With this consent, the office of **Debra L. Balke, M.D.** may e-mail to my home or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that **Debra L Balke, M.D.** 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 is bound by this agreement.

By signing this form, I am consenting to **Debra L Balke, M.D.'s** uses and disclosures 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 coy prior consent. If I do not sign this consent, or later revoke it, **Debra L. Balke, M.D.** may decline to provide treatment to the above-named person.

Signature of Parent or Legal Guardian

Patient's Name

Print Name of Parent or Legal Guardian

Date