Advanced Pediatrics Group LLC
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES OF ADVANCED PEDIATRICS GROUP AND CONSENT FORM

By signing below, I hereby acknowledgment that I received a copy of Advanced Pediatrics Group Notice of Private Practices as required by Federal Law in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Advanced Pediatrics Group has my consent to use and disclose protected health information (PHI) , about my child to carry out treatments, payment and healthcare operations (TPO). Please refer to Advanced Pediatrics Group's Notice of Private Practices for a complete description of such uses and disclosures.

With my consent, Advanced Pediatrics Group may call my home or other designated locations and leave a message on voicemail, related to any items that assist the practice in carry out TPO, such as appointments reminders, insurance item and any call pertaining my child's clinical care, including any test results.

By signing below, I am giving my consent to the Physicians and Staff of Advanced Pediatrics Group to administer medical treatment as considered necessary in and all of my child/ children's office visit and Telemedicine consultations. I also give my consent for Advanced Pediatrics Group to submit charges to my insurance company for payment for any and all treatments administered to my child.

I may revoke my consent at any time, in writing and dated signature. However, I agree that I authorize any information released prior to the date I revoke my consent.

Without signing this consent form, Advanced Pediatrics Group may decline to provide treatment to my child.

Parent/ Guardian Print Name _____

Parent/ Guardian Signature _____