Protected Health Information Disclosure Statement

Windermere Pediatrics, PA
7635 Ashley Park Court
Suite 501
Orlando, FL 32835
Phone: 407-297-0080 Fax: 407-295-3080

In connection with the medical services my child is receiving at Windermere Pediatrics, I consent to and authorize the physicians and their staff to use and disclose any and all Protected health Information (PHI) necessary to carry out treatment, payment and healthcare operations (TPO) related to my child's medical care. I understand the Notice of Privacy Practices is available from the receptionist and that it offers a more complete description of uses and disclosures. This office reserves the right to review and change our Notice of Privacy Practices at any time.

Windermere Pediatrics may call my home, office, or emergency contact and leave a message 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 child's health care.

Windermere Pediatrics may mail to my home or office any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements.

I have the right to request that this practice restrict how they use or disclose my protected health information (PHI) to carry out treatment, payment and health care operations (TPO). However, this office is not required to agree to my requested restrictions, but if they do, the office is bound by this agreement.

By signing this form, I consent to the use and disclosure of my child's PHI to carry out treatment, payment and health care operations (TPO). This consent may be revoked by submitting a request in writing. If I decline to sign this consent, Windermere Pediatrics may decline to provide treatment.

Printed Patient Name: ____

Printed Name of Parent/Legal Guardian: ____

Signature of Legal Guardian: ____ Date: ________________