CONSENTS AND PERMISSION TO TREAT

I hereby authorize the medical treatment of ALL my children listed on the GENERAL INFORMATION page by TLC Pediatric & Adolescent Medicine, P.A.

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Signed (Parent/Guardian) Date

I hereby authorize payment directly to TLC Pediatric & Adolescent Medicine, P.A. I will be responsible for all monies deemed by my insurance company to be patient responsibility. In addition, I understand some services may be determined to be non-covered services by my insurance company, and I will be responsible for such services.

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Signed (Parent/Guardian) Date

I hereby authorize release of any of my children's medical records necessary to process insurance claims or referrals. Some information may be transmitted electronically and/or via internet.

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Signed (Parent/Guardian) Date

I authorize email communication with TLC Pediatric & Adolescent Medicine, P.A., and it is my responsibility to notify TLC Pediatric & Adolescent Medicine, P.A. in writing of any change in email address or desire to revoke this consent for electronic communication.

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Signed (Parent/Guardian) Date

ACCT #____________

TLC Pediatric & Adolescent Medicine, P.A.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for TLC Pediatric & Adolescent Medicine, P.A. to use and disclose protected health information (PHI) about my child(ren) to carry out treatment, payment and healthcare operations (TPO).TLC Pediatric & Adolescent Medicine's Notice of Privacy Practices provides 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. TLC Pediatric & Adolescent Medicine, P.A. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to TLC Pediatric & Adolescent Medicine, P.A. Privacy Officer at 11715 Orpington Street, Suite A, Orlando, Florida, 32817.

With this consent, TLC Pediatric & Adolescent Medicine, P.A. may call my home or other alternative location and leave a message on voice mail 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 and radiology results among others.

With this consent, TLC Pediatric & Adolescent Medicine, P.A. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, school immunization and/or physical forms; all correspondence will be marked Personal and Confidential.

With this consent, TLC Pediatric & Adolescent Medicine, P.A. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO. I have the right to request that TLC Pediatric & Adolescent Medicine, P.A. 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 TLC Pediatric & Adolescent Medicine, P.A.'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, or later revoke it, TLC Pediatric & Adolescent Medicine, P.A. may decline to provide treatment to me.

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Signature: Legal Guardian

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Print Name of Legal Guardian

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Date