Washington University Clinical Associates - Northwest Pediatrics, L.L.C.

Authorization and Consent to Contact and
Leave Message, Voice Mail and/or Message with Answering Party

I am providing this authorization and consent to enable Washington University Clinical Associates - Northwest Pediatrics, L.L.C. ("WUCA-NWP") to call my home or other designated location and leave a message on voice mail or in person with any answering party in reference to any items that assist WUCA-NWP to carry out treatment, payment and healthcare operations ("TPO"), such as appointment reminders, insurance items, results or other matters pertaining to clinical tests or care, including laboratory test results among others. The message may include health information ("PHI"), the confidentiality of which is otherwise protected under the Health Insurance Portability and Accountability Act ("HIPAA").

WUCA-NWP may mail to my home or other designated location or e-mail any items that assist the practice in carrying out TPO, such as the above referenced items and patient statements.

By signing this form, I am consenting to WUCA-NWP's use and disclosure of my PHI to carry out TPO.

I may revoke this authorization and consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

I represent that I have authority to provide this authorization and consent for the patient.

____
Signature of Patient of Legal Guardian

______________________________________ __________________________
Patient's Name Date

____
Name of Patient or Legal Guardian

____
Address

____
E-Mail Address

____
Telephone Number