

Exhibit 5
East Aurora Pediatrics, PC

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, **East Aurora Pediatrics** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **East Aurora Pediatric'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. **East Aurora Pediatrics** 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 **East Aurora Pediatrics** Privacy Officer at 94 Olean Street, East Aurora, NY 14052.

With my consent, **East Aurora Pediatrics** may call my home or other designated location and leave a message 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 call pertaining to my clinical care, including laboratory and radiology results among others.

With my consent, **East Aurora Pediatrics** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that **East Aurora Pediatrics** 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 it does, it is bound by this agreement.

With my consent, **East Aurora Pediatrics** may fax to my child's school or day care provider a copy of their immunization record and Health Appraisal Forms.

By signing this form, I am consenting to **East Aurora Pediatrics'** 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, **East Aurora Pediatrics** may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name

Date

Print Name of Patient or Legal Guardian