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## Acknowledgment of Receipt of Notice of Privacy Practices:

_____ Initial — I have received this office's Notice of Privacy Practices, which explains how my children's medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

## HIPAA PRIVACY POLICY:

I. Please list the family members or other persons, if any, whom we may inform about your child/children's general medical condition and diagnosis (Including treatment, payment, and health care operations):

_____
_____

II. Please list those whom you have authorized to seek medical attention and treatment for your child/children during your absence. ANY ONE NOT LISTED ON THIS FORM WILL NEEED A SEPARATE NOTE FROM YOU in order for us to see your child/children in your absence. All persons seeking medical treatment in your place must be 18 years or older and have a valid ID.

_____
_____

III. Can confidential messages (e.g., appointment reminders, lab and x-ray results) be left on your telephone answering machine or voicemail? ____Yes ____No

_____ Initial *I AM FULLY **AWARE** THAT A CELL PHONE IS NOT A SECURE AND PRIVATE LINE.*

_____ Signature of Parent or Legal Guardian

_____ Date

_____ Print Name of Parent or Legal Guardian

_____ Legal relation to child(ren)

List name(s) of child(ren) covered by this form:

_____ _____
_____ _____
_____ _____

This ***Release of Information*** will remain in effect until terminated by me in writing.