Privacy Practices Acknowledgement

It is important for us to honor the confidentiality between patient and physician. Therefore, we ask that you provide us with any names of family members or another party that you authorize us to discuss you/your child's medical care or concerns with, should we be contacted by them. Note that by law it is a requirement that we release requested medical information to your insurance company, Medicare, Medicaid, Social Security Administration or any federal state or government request.

_____ _____

Patient's Name Age

Please check your preference below:

_____ You may discuss my/my child's medical concerns only with me.

_____ It is permissible to discuss my/my child's medical information or concerns with the following people should they contact my physician.

1) _____ Relationship: _____ Phone: _____

2) _____ Relationship: _____ Phone: _____

3) _____ Relationship: _____ Phone: _____

4) _____ Relationship: _____ Phone: _____

____ You may leave information on my telephone answering machine if needed.

I understand that I can and will provide a written request to change the above authorization information or contacts. Such written request will note specifically with whom my/my child's physician may discuss my/his/her medical care. I acknowledge that I also have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____

Print Name of Legal Guardian

_____ _____

Signature of Patient or Legal Guardian Date