
1. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received and read a copy of this office's *Notice of Privacy Practices*.

Patient Name: _____

Parent/Guardian Name: _____
(relationship to patient)

Signature Date

FOR OFFICE USE ONLY

We attempted to obtain the written acknowledgment of receipt of our Notice of Privacy Practices, but were unable to do so as documented herein.

Date: ____/____/____ Initials: _____ Reason: _____

2. AUTHORIZATION FOR ACCESS TO HEALTH INFORMATION

I, _____, parent/guardian of the above named patient, authorize the following individuals to have access to and be informed of the above named patient's medical information and medical care. *(Individual must be a legal adult with one form of identification)*

Signature: _____ Date: _____

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

3. CONSENT TO TREATMENT AND PAYMENT

I, the parent or guardian of the above named child, authorize this office to provide medical care for this said individual. I understand that confidentiality of medical information and patient rights will be maintained as detailed by HIPAA regulations. I authorize the submission of any medical claims related to my child's care using standard medical office billing procedures. I understand that my consent is valid for one year from the date below and will be renewed annually or upon returning for medical care.

Signature: _____ Date: _____
