

HIPAA / Release of Information		
	ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES (You may refuse to sign this acknowledgement), have received a copy of the Notice of Privacy Practices of The Place, LLC. Ily allow the following persons access to the protected medical information: MEDIA RELEASE AUTHORIZATION	
	(You may refus	e to sign this acknowledgement)
l,	, ha	ave received a copy of the Notice of Privacy Practices of The
Pediatric Place, LLC	ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES (You may refuse to sign this acknowledgement), have received a copy of the Notice of Privacy Practices of The tric Place, LLC. ifically allow the following persons access to the protected medical information: In the Name: Interior of patient or guardian: Interior of patient: MEDIA RELEASE AUTHORIZATION Derize The Pediatric Place, LLC and its authorized employees or agents to publish photographs or other identifying information of my child/self to their website, social media, or print media. The protection of my child/self to their website, social media, or print media. The protection of my child/self to their website, social media, or print media. The patient Name: Signature: Patient Name: Illowing information is NOT allowed to be disclosed: FOR OFFICE USE ONLY Interior of patient in attempting to obtain written acknowledgement of receipt of the end of Privacy Practices. Acknowledgement could not be obtained for the following reason(s): Interior guardian refused to sign (Date of Refusal): Imunication barriers prohibited obtaining an acknowledgement mergency situation prevented us from obtaining an ackno	
I specifically allow the		
Patient Name:		
Signature of patient of	or guardian:	
Relation to patient:		
Date:		
	MEDIA RE	LEASE AUTHORIZATION
I authorize The Pedia	atric Place, LLC and its autho	orized employees or agents to publish photographs
and/or other identifyi	ng information of my child/se	If to their website, social media, or print media.
□ I agree	□ I do NOT agree	Date:
Printed Name:		Signature:
Relation to patient:		Patient Name:
The following informa	ation is NOT allowed to be di	sclosed:
	FOR	OFFICE USE ONLY
We have made a goo	od faith effort in attempting to	obtain written acknowledgement of receipt of the
Notice of Privacy Pra	ctices. Acknowledgement co	ould not be obtained for the following reason(s):
□Parent or guardian	refused to sign (Date of Refu	usal):
□Communication bar	rriers prohibited obtaining an	acknowledgement
□An emergency situa □Other:	ation prevented us from obta	ining an acknowledgement
Attempt made by:		