HIPAA / Release of Information

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

(You may refuse to sign this acknowledgement)

I, _____, have received a copy of the Notice of Privacy Practices of The Pediatric Place, LLC.

I specifically allow the following persons access to the protected medical information:

_____

_____

_____

_____

Patient Name: _____

Signature of patient or guardian: _____

Relation to patient: _____

Date:

MEDIA RELEASE AUTHORIZATION

I authorize The Pediatric Place, LLC and its authorized employees or agents to publish photographs and/or other identifying information of my child/self 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 information is NOT allowed to be disclosed:

FOR OFFICE USE ONLY

We have made a good faith effort in attempting to obtain written acknowledgement of receipt of the Notice of Privacy Practices. Acknowledgement could not be obtained for the following reason(s):

□Parent or guardian refused to sign (Date of Refusal):

□Communication barriers prohibited obtaining an acknowledgement

□An emergency situation prevented us from obtaining an acknowledgement

□Other: _____

Attempt made by: