ACKNOWLEGDEMENT OF HIPAA PRIVACY NOTICE AND DESIGNATION OF DISCLOSURE

I. Acknowledgement of HIPAA Privacy Notice:

I have received a copy of the Notice of HIPAA Privacy for the Physician Practice.

_____	_____	_____	_____
Name of Patient (minor)	Date of Birth	Signature of Parent/Guardian	Date

II. Designation of Disclosure:

Sign in sheet: Our office uses a sign in sheet. If you have any objection to signing your child's name on the sheet; please tell our office staff and she will assign your child a number.

Appointment reminders:

I give the office permission to send a reminder **postcard** to my home. **Yes ___ No ___**

I give the office permission to call me and remind me of an appointment. **Yes ___ No ___**

( ) Please call my home phone: _____

( ) Please call my cell phone: _____

( ) Please call my work phone: _____

If we get a voice mail, may we leave a brief message? **Yes ___ No___**

If we get a family member, may we leave a message? **Yes ___ No ___**

If yes, please indicate who we may leave a message with:

_____ Relationship: _____

_____ Relationship: _____

Test Results (laboratory, X-ray, etc.): Our office will call you when we receive test results.

We will make every attempt to reach you personally. If we cannot reach you personally:

May we leave a message on the voice mail to have you call the office? **Yes ___ No ___**

May we leave routine test result(s) on your voice mail? **Yes ___ No ___**

May we call you at work? **Yes ___ No ___**

Policy for discussing medical information:

Our office will not discuss your child's medical information with anyone other than you, the parents. If you want to authorize the release of your child's personal health information to another party, you will be required to fill out an "authorization form". Please ask a staff member for this form.

Parent's name: _____
Please print

Parent's signature: _____ Date signed: _____