PEDIATRICZ NOW

ACKNOWLEDGEMENT OF THE RECEIPT OF PEDIATRICZ NOW'S NOTICE OF HEALTH INFORMATION PRACTICES, OFFICE AND FINANCIAL POLICIES

The Health Insurance Portability and Accountability Act (HIPPA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your child's medical information can be used by our staff in providing and arranging your medical care. Pediatricz Now is furnishing you with the attached notices, which provides information about how Pediatricz Now may use and/or disclose protected health information about your child for treatment, payment, healthcare operations and as otherwise allowed by law. You shall also be given a copy of the office and financial policies for Pedatricz Now. By signing this form, you acknowledge that you have received a copy of Pediatricz Now notice of Private Health information, office, and financial practices and policies.

Patient's Name _____ Patient's Date of Birth _____

Signature of Parent or Legal Guardian _____ Date _____

Patient Preference Regarding Communications of Health Information

I hereby give permission to Pediatricz Now to disclose and discuss any information related to my child's medical condition(s) to/ with the following family member(s), other relative(s) and/or close personal friend(s):

Name _____ Relationship _____ Contact Information _____

Name _____ Relationship _____ Contact Information _____

Name _____ Relationship _____ Contact Information _____

Parent Consent for Minor Child

The following adult family member(s) and/or adult family friend may consent to healthcare treatment of my child when I am not available:

Name _____ Relationship _____ Phone Number _____

Name _____ Relationship _____ Phone Number _____

Name _____ Relationship _____ Phone Number _____

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

Signature of Parent or Legal Guardian _____ Date _____