Notice of Privacy Practice Policy (HIPAA)

Patient Name: _____ DOB: _____

Patient Address:

Street/P O Box _____

City, State, and Zip Code: _____

PLEASE CHECK OR RESTRICT ALL THAT APPLY:

Telephone Numbers:

Home: _____
Work: _____
Cell: _____
Fax: _____
Other: _____

_____ _____
Signature: Parent/Legal Guardian Date

PLEASE LIST ALL PEOPLE ALLOWED TO BRING IN YOUR CHILD FOR APPOINTMENTS AND MEDICAL TREATMENTS:

Name: _____ Phone: _____ DOB: _____ Relation: _____

Name: _____ Phone: _____ DOB: _____ Relation: _____

Name: _____ Phone: _____ DOB: _____ Relation: _____

Name: _____ Phone: _____ DOB: _____ Relation: _____

_____ _____
Signature: Parent/Legal Guardian Date

PLEASE LIST IF YOU AUTHORIZE OFFICE TO SEND YOU ELECTRONIC INFORMATION AT YOUR REQUEST: Ex: copy of labs, visits, statements, excuses, receipts.

Email: _____ Text: _____ Fax: _____

_____ _____
Signature: Parent/Legal Guardian Date