ALMOUIE PEDIATRICS

ACKNOWLEDGEMENT OF THE RECEIPT OF ALMOUIE PEDIATRICS' NOTICE OF HEALTH INFORMATION PRACTICES, OFFICE AND FINANCIAL POLICIES

The Health Insurance Portability and Accountability Act (HIPAA) 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.
Almouie Pediatrics is furnishing you with the attached notices, which provides information about how Almouie Pediatrics 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 Almouie Pediatrics. By signing this form, you acknowledge that you have received a copy of Almouie Pediatrics' 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 Communication of Health Information

I hereby give permission to Almouie Pediatrics 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