The Pediatric Group, PLLC

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

Patient Name:_____ DOB:_____

I have received a copy of The Pediatric Group, PLLC's Notice of Privacy Practices.

_____ _____

Signature of Parent or Legal Guardian Date

INSTRUCTIONS REGARDING LEAVING REMINDER CALLS ON HOME MESSAGE RECORDER

I □ give permission □ do NOT give permission

to the physicians or staff members of The Pediatric Group, PLLC to leave a message(s) on my home recorder for the purpose of reminding me that my child/ren has/have an scheduled appointment.

INSTRUCTIONS REGARDING LEAVING HEALTH CARE INFORMATION ON HOME MESSAGE RECORDER

I □ give permission □ do NOT give permission

to the physicians or staff members of The Pediatric Group, PLLC to leave a message(s) on my home recorder for the purpose of informing me of medical information about my child/ren, including results of diagnostic tests, specialists' impressions, and/or other medical information necessary for the continuing care of my child/ren.

INSTRUCTIONS REGARDING PROVISION OF IMMUNIZATION RECORDS WITHOUT WRITTEN AUTHORIZATION

I □ give permission □ do NOT give permission

to the physicians or staff members of The Pediatric Group, PLLC to provide a copy of my child's immunization record (only) to any person or facility I designate via a telephone call to the practice. I understand that this authorization replaces a written authorization for each specific release.

THE FOLLOWING NAMED INDIVIDUALS MAY RECEIVE INFORMATION ABOUT MY CHILD'S HEALTH CARE/CONDITION (Please include both parents if applicable)

Name	**Relationship**	**Email Address**	**Phone#**

_____ _____

Signature of Parent or Legal Guardian Date

Rev 10/13