Healthy Beginnings Pediatrics

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Notice of Privacy Practices Acknowledgement

Patient Consent to the Use and Disclosure of Health Information for
Treatment, payment, or health Care Operations

The following person(s) may accompany patient to appointment if guardian is unable and may also discuss treatment plan and payment information: **(Please list the names and relationship)**

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Restrictions:
I request the following restriction to the use or disclosure of my child's health information:

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Messages or Appointment Reminders: (Please check all that apply)
May we leave a message on your voicemail at home [ ] cell phone [ ] or at work [ ].
Do not leave a message [ ].
May we leave a message with someone at home using the doctor's name or the practice name: Yes [ ] No [ ].
Messages will be of a non-sensitive nature, such as appointment reminders.

I fully understand and accept the information provided within the Notice of Privacy Practices.

I am the parent, legal guardian, custodian, or have Power of Attorney for this patient for treatment, payment, or health care operations:

_________________________ _______________________________ __________
Signature Printed name/relation Date

______________________________ _______________
Witness Date

Names of the children that this notice applies to: (Please print)

First Name **Last Name** **Date of Birth**

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