Kinder Life Pediatrics

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Acknowledgement of Receipt of Privacy Practices

Patient Information

Last Name: _____ First Name: _____ Middle Name: _____

DOB: _____ Sex: _____

I have been presented with a copy of the Notice of Privacy Practices, detailing how my child's health information may be used and disclosed as permitted under federal and state law, and outlining my right regarding my health information.

Also, by signing this document, I authorize the individuals listed below to bring my child to **Kinder Life Pediatrics** for treatment. This authorization is valid until requested otherwise.

Parent's/ Guardian's Name: _____

Relationship with Patient: _____

Legal Guardian's Signature: _____ Date: _____

I want **Kinder Life Pediatrics** to give me reminder calls about upcoming appointments ☐ YES ☐ NO

Authorized Persons Lists <u>(Other than Parents)</u>

First Name	Middle Initial	Last Name	Phone #	Relationship with Patient