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## **Acknowledgment of Receipt of Notice of Privacy Practices:**

I have received this office's Notice of Privacy Practices, which explains how my child(ren)'s medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

\_\_\_\_\_ (Signature)

### PATIENT PRIVACY QUESTIONNAIRE:

1. Please list the family members or other persons, if any, whom we may inform about your child/children's general medical condition and diagnosis (including treatment, payment, and health care operations:)

\_\_\_\_\_  
\_\_\_\_\_

2. Please list the family members or other persons, if any, who have your permission to bring your child/children.

\_\_\_\_\_  
\_\_\_\_\_

3. Please print the telephone number where you want to receive calls about your child/children's appointments, lab and x-ray results, or other health care information if other than your home phone number.

\_\_\_\_\_.

### **I AM FULLY AWARE THAT A CELL PHONE IS NOT A SECURE AND PRIVATE LINE.**

4. Can confidential messages (e.g. appointment reminders) be left on your telephone answering machine or voicemail? \_\_\_\_ yes \_\_\_\_ no

\_\_\_\_\_  
Signature of parent/legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of parent/legal guardian

\_\_\_\_\_  
Legal relation to child(ren)

List names(s) of child(ren) covered by this form:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_