Acknowledgment of the Receipt of CareVille Pediatrics P.A notice of Health Information Practice Office and Financial Policies

The Health Insurance Portability and Accountability Act (HIPPA) 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.

Upon your request you shall be given a copy of the office and financial policies for CareVille Pediatrics, P.A. By signing this form, you acknowledge that you have received a copy of CareVille Pediatrics, P.A notice of Private Health Information, office, and financial practice and policies.

Patient's Name:_____ DOB:_____

Signature of Parent/Guardian: _____ Date: _____

Patient preference regarding Communication of Health Information

Is there anyone who can take a message about your child/ren health care or results? _____

I hereby give permission to CareVille Pediatrics, P.A 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 friends(s):

Name: _____ Relationship: _____

Phone #: _____ Message to call office/detailed message.

Name: _____ Relationship: _____

Phone #: _____ Message to call office/detailed message.

Name: _____ Relationship: _____

Phone #: _____ Message to call office/detailed message.

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/Guardian:_____Date:_____