NOTICE OF PRIVACY PRACTICES AND DISCLOSURES ALLOWANCES

Acknowledgement of Receipt

I, _____, acknowledge that I was provided a copy of the Notice of
(Print parent/guardian name)

Privacy Practices.

_____
(Parent/Guardian Signature) (Date)

Relationship to patient _____

Patient Name/DOB _____
(Last name) (First name) (DOB)

I authorize the disclosure of my child's health and financial information to the following family members or personal representatives:

_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship

_____ _____
Print Parent/Guardian Name Signature of Parent/Guardian