PITTSFORD PEDIATRIC ASSOCIATES

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59-B MONROE AVENUE
PITTSFORD, NEW YORK 14534
TELEPHONE (585) 385-1710

DATE: _____

PATIENT'S NAME: _____

I consent to the examination and treatment of my child as named above, by the physicians and nursing staff of Pittsford Pediatric Associates.

I authorize Pittsfoed Pediatric Associates to release any and all of my child's medical records to another physician or any other health care professional for the purposes of discussing and or obtaining medical care for my child.

Such records may include office notes, clinical laboratory reports, diagnostic test results, x-ray reports, as well as other pertinent medical information pertaining to my child (including immunizations).

These records in their entirety may also be released to insurance companies and their employees for the purpose of pursuing payment, insurance reimbursement or performing quality assurance reviews as required by the insurance company or by law.

Please remember that medical insurance is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-pay, co-insurance amount, or any other balance not paid for by your insurance.

I, the undersigned, on behalf of my child named above, realize I am financially responsible for all charges whether or not paid by my insurance company.

This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN DATE

REAUTHORIZATION

_____ _____

_____ _____

_____ _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
Please print your name here

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgment.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

_____

_____

_____ _____
Employee Signature *Date*