21 B Arts Center Court
Avon, CT 06001

1. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been offered or received a copy of this office's *Notice of Privacy Practices.*

All Patient Names:____

Parent/Guardian Name:____

(relationship to patient)

____ ___________________________

Signature Date

2. AUTHORIZATION FOR ACCESS TO HEALTH INFORMATION

I, _______________________________, parent/guardian of the above named patient, authorize the following individuals to have access to and be informed of the above named patient's medical information and medical care. Individual must be a legal adult with one form of identification. (i.e. grandparents, nanny, aunts, etc.)

Signature:____Date:________________________

Name:____Relationship__________________

Name:____Relationship__________________

Name:____Relationship__________________

Name:____Relationship__________________

3. COMMUNICATION AGREEMENT

I, the parent or guardian of the above named child, understand that Hartford Area Pediatrics will have to contact me in order to remind me of appointments, provide test results, give instructions or provide other information. I have indicated my preferred method of contact on the registration form.

Signature:____Date:_____________________________

4. CONSENT TO TREATMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

I, the parent or guardian of the above named child, authorize this office to provide medical care for this said individual. I understand that confidentiality of medical information and patient rights will be maintained as detailed by HIPAA regulations. I authorize the release of information to any physician involved in my child's care, as well as to my insurance company to process my medical claims.

Signature:____Date:_____________________________

FOR OFFICE USE ONLY

We attempted to obtain the written acknowledgment of receipt of our Notice of Privacy Practices, but were unable to do so as documented herein.

Date:_____/______/_____ Initials:__________ Reason:____