### **ACKNOWLDEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have been offered and/or received from *Mante Pediactrics* Notice of Privacy Practices

## **Patient Information**

| 1. First Name:         | Middle Name Last Na                                   | me:                     |          |
|------------------------|---|-------------------------|----------|
| Date of Birth:         | School Child Attends:                                 | Grade                   | _ M or F |
| 2. First Name:         | Middle Name Last Na                                   | me:                     |          |
| Date of Birth:         | School Child Attends:                                 | Grade                   | _ M or F |
| 3. First Name:         | Middle Name Last Na                                   | me:                     |          |
| Date of Birth:         | School Child Attends:                                 | Grade                   | _ M or F |
| I. First Name:         | Middle Name Last Nai                                  | me:                     |          |
| Date of Birth:         | School Child Attends:                                 | Grade                   | _ M or F |
| 5. First Name:         | Middle Name Last Na                                   | me:                     | _        |
| Date of Birth:         | School Child Attends:                                 | Grade                   | _ M or F |
| Address:               |   |                         |          |
| City:                  | State: Zip Code:                                      |                         |          |
| Home Phone: ()         | Cell Phone: () Ethnicity: N                           | Not Hispanic/Hispanic/C | Other    |
| Work Phone: ()         | Other Phone: () Language:                             | English/ Spanish/ Other |          |
| Race: White, Black/ Af | rican Americans, Hispanic/Latino, Asian, Native Amer  | ricans/Alaska Natives   | or Other |
| E-MAIL ADDRESS:        |   |                         |          |
|                        |   |                         |          |
|                        |   |                         |          |
| ather Name:            |   |                         |          |
|                        | Legal Guardian Parent of Minor Po                     |                         | Self     |
| Parent/Guardian's      | Signature:  |                         |          |
| Print Parent/Guard     | ian's Full Name:<br>*******************************   | *******                 | ***      |
| Name and location      | of the Pharmacy that you use for your child/children: |                         |          |
|                        | and   |                         |          |
| (Name                  | e) (Lo  | ocation)                |          |

Permission to Use and Disclose Protected Health Information. You may communicate with the following individuals regarding my Protected Health Information: (Please list anyone and everyone over the age of 18 with an ID that has permission to bring your child/children to our office or to go in the back with you)\*\*IF NOT ON FORM THEY WILL NOT BE

ALLOWED TO BRING YOUR CHILD(REN) TO ANY APPOINTMENTS NOR GO IN BACK WITH YOU\*\*

| Name                 | Relationship         | Phone Number                             |                     |
|----------------------|----------------------|--|---------------------|
| 2Name                | Relationship         | Phone Number                             |                     |
| Name                 | Relationship         | Phone Number                             |                     |
| 4Name                | Relationship         | Phone Number                             |                     |
| Name                 | Relationship         | Phone Number                             |                     |
| 6                    | Relationship         | Phone Number                             |                     |
|                      | Mante I              | Pediatrics                               |                     |
|                      | Dr. Ebeneze          | r Mante, M.D.                            |                     |
|                      |                      | ce company with<br>laim(s), I/We will be |                     |
|                      | ndered for my servic |  | responsible for all |
| Parent's Signature   | Da                   | te                                       |                     |
| Guardian's Signature | <br>e Da             | te                                       |                     |

# Notice of Privacy Practices and Patient Consent for Use and Disclosure of Protected Health Information

| PATIENT NAME   | DOB   |  |  |  |  |
|--|---|--|--|--|--|
| nderstand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certa tient Rights regarding my protected health information.   |   |  |  |  |  |
| payment or health care operations—which means for pand payment; and, taking care of other health care ope  | rstand that Mante Pediatrics may use or disclose my protected health information for treatment, ent or health care operations—which means for providing health care to me, the patient; handling billing syment; and, taking care of other health care operations. Unless required by law, there will be no other and disclosures of this information without my authorization. |  |  |  |  |
| lante Pediatrics has a detailed document called the 'Notice of Privacy Practices'. It contains a more complete<br>escription of your rights to privacy and how we may use and disclose protected health information.   |   |  |  |  |  |
| understand that I have the right to read the 'Notice' before signing this agreement. If I ask, Mante Pediatrics will provide me with the most current Notice of Privacy Practices.   |   |  |  |  |  |
| My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow Mante Pediatrics to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Mante Pediatrics has taken action relying on this consent. |   |  |  |  |  |
| SIGNATURE (Parent, Patient or Legal Custodian/Author   | rized Representative) DATE  |  |  |  |  |
| Relationship to Patient  | DATE  |  |  |  |  |
| You may obtain a copy of our Notice of Privacy Practic   | ces, including any revisions of our 'Notice' at any time  |  |  |  |  |

by contacting: HIPAA Officer, Mante Pediatrics901 West Meeting St. Ste. 203, Lancaster, SC 29720, Tel. 803-

313-3846

FORM Us



### 901 W. Meeting St Suite 203 Lancaster, SC 29720

Phone: (803) 313-3846 Fax: (803) 313-3847

### \*\*AUTHORIZATION TO DISCLOSE HEATLH INFORMATION AND RELEASE OF RECORDS\*\*

| First Name:               | Middle Name:  | Last Name:                                     | DOB:             |
|---------------------------|---|--|------------------|
| First Name:               | Middle Name:  | Last Name:                                     | DOB:             |
| First Name:               | Middle Name:  | Last Name:                                     | DOB:             |
| First Name:               | Middle Name:  | Last Name:                                     | DOB:             |
| First Name:               | Middle Name:  | Last Name:                                     | DOB:             |
| Street Address:           |   |  |                  |
|                           | State: Zip code:  |  |                  |
| Home Phone # ()           | Cell #  | ()   |                  |
| Information released f    | rom:  |  |                  |
| Information released t    | o:  |  |                  |
|                           | Mante Pediatrics  | 5-00-70-00-10-10-10-10-10-10-10-10-10-10-10-10 |                  |
| This information should   | d include: *ALL RECORD TO E   | BE RELEASED UNLESS OTHE                        | RWISE SPECIFIED* |
| Entire record             | Shot record   | othe   | r                |
| Purpose of Record Rel     | ease:   |  |                  |
| Change of PCP             | Continuin   | g Treatment                                    | Personal         |
| days from date of signatu | e of health information for the ab<br>re. I understand that I may cance<br>ormation released prior to notific | el this request with written not               |                  |
| Signature of legal guard  | dian:   |  | Date:            |
|                           | :   |  |                  |
| Witness:                  |   | Date:  |                  |