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# Notice of Privacy Practice Policy – HIPPA

Patient Name: ________________________________________ DOB: _____/_____/______

Mailing Address: ______________________________________________

City: _________________________ State: __________ Zip Code: _______

**Please list ALL people allowed to bring in your child for appointments and medical treatments:**

Name: ____________________ Relationship: _________ DOB: __/___/___Phone #: __________

Name: ____________________ Relationship: _________ DOB: __/___/___Phone #: __________

Name: ____________________ Relationship: _________ DOB: __/___/___Phone #: __________

Name: ____________________ Relationship: _________ DOB: __/___/___Phone #: __________

________________________________________ _______________

Signature: Parent/ Legal Guardian Date

**PLEASE LIST IF YOU AUTHORIZE OFFICE TO SEND YOU ELECTRONIC INFORMATION AT YOU REQUEST (PORTAL):** Ex: Vaccine record, copy of labs, visits, statements, excuses, receipts.

Email: ________________________________ Fax: ___________________

________________________________________ _______________

Signature: Parent/ Legal Guardian Date