DLC Pediatrics
Martin Garza, M.D., P.A.

Notice of Privacy Practice Policy – HIPPA

Patient(s) Name: _____ DOB: _____/_____/_____

_____ DOB: _____/_____/_____

_____ DOB: _____/_____/_____

_____ DOB: _____/_____/_____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Please list all persons that may have access to your child's medical information. Example: appointments, prescription pick up, general medical information, lab results or medical emergencies. If their name and phone number is not on the list, they will not be allowed to have any information on the patient. Please make sure to update any changes at each appointment.

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 YOUR REQUEST (PATIENT PORTAL / TEXT MESSAGING):
Ex: Vaccine record, copy of labs, visits, statements, excuses, receipts, appointment reminders.

Email: _____ Cell: (____)_____-_____

Fax: (____)_____-_____

_____ _____

Signature: Parent/ Legal Guardian Date