OFFICE USE ONLY
Patient Number: ______________________
Date of Birth: ________________________
Date Received Notice: ________________

Pediatrics South

(18 YRS AND OLDER)

Acknowledgement of Receipt of Privacy Notice and Confidentiality Form

Patient Name: ____

Cell Phone Number: ____

Please list the family members or other persons, if any, whom we may inform about your general medical conditions/test results/emergency condition.

_____________________________________Phone#______________Relationship__________
_____________________________________Phone#______________Relationship__________
_____________________________________Phone#______________Relationship__________

**I am fully aware that a cell phone is not a secure and private line*

May we leave a message regarding appointment reminder at all phone numbers that you have listed on our registration form?

Yes __________ **No** _________

If **no**, please list the phone number where we can contact you. ___________________

May we leave a message at all phone numbers that you have listed on our registration form if we need to contact you with regard to your medical test's results?

Yes __________ **No** _________

If **no**, please list the phone number where we can contact you. ___________________

May a staff member, triage nurse or physician leave a message for you to return their call on a voice mail system, an answering machine, or person if you are not available?

Yes __________ **No** _________

May we fax your pertinent medical information to other physician's offices or other medical facilities when medically necessary?

Yes __________ **No** _________

May we fax or mail your medical information to insurance companies or schools?

Yes __________ **No** _________

***Please list any other restrictions regarding release of medical records**.

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____________________________________ ___________________ ___________

Patient's Printed Name **Signature** **Date**

*I acknowledge that I received the Notice of Privacy Practices for Pediatrics South.

2017