

PERFORMANCE PEDIATRICS

Acknowledgment and Consent Form

Patient Name: _____
Last First Middle

Home Address: _____

Home Telephone: _____ **Date of Birth:** _____

Please note that all references to "me" and "my" below refer to the patient.

Acknowledgment of Receipt of Notice of Privacy Practices:

By my signature below, I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

Consent to Disclose My General Health Information:

By my signature below, I hereby authorize the Practice to disclose my medical information so that the Practice may treat me, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations (e.g., quality assurance). I also authorize the Practice to disclose my medical information to insurers and providers outside of the Practice when necessary so that these providers may treat me, seek payment for that treatment, and for the purpose of their health care operations. I also authorize the Practice to disclose my email address to an on-line organization so that I may receive a monthly patient e-newsletter from the Practice. I also authorize the Practice to disclose my medical information on my home answering machine/voicemail and to the following individuals (e.g., family members, caregivers, friends, or "none"):

Consent to Disclose My Highly Confidential Information:

I understand that my medical record currently contains or may contain in the future the following types of highly confidential information. By my signature below, I specifically consent to the disclosure of such information as part of my medical record to insurers and providers outside the Practice for the purpose of obtaining treatment for me, payment for the treatment provided to me, and so that these entities can carry out their health care operations.

- information about genetic testing
- information related to confidential communications with a psychotherapist, psychologist, social worker, sexual assault counselor, domestic violence counselor or other allied mental health professional or human services professional
- information about venereal disease(s)
- abortion consent form(s)
- mammography records
- information about family planning services
- if I am an emancipated minor, information about my treatment and diagnosis (except to my parents)
- information about research involving controlled substances

To the extent that you do not consent to the disclosure of any of the information listed above, please cross it out.

Signatures

The signature of the Patient is required if the Patient is 18 or older, or is an emancipated minor.

Signature of Patient

Date

The signature of a Personal Representative (e.g., parent or legal guardian) is required if the Patient is an unemancipated minor or otherwise incapacitated (physically or mentally).

Signature of Personal Representative

Description of Authority

Date