

1906 Glenn Blvd SW Ste 100-A • Fort Payne, AL 35968 Phone: (256) 997-5900 • Fax: (256) 997-5995

## Acknowledgment of Receipt of Notice of Privacy Practices and HIPAA Release Form

I have reviewed this office's Notice of Privacy Practices which explains how my chid(ren)'s medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon my request.

## **Patient Privacy Questionnaire:**

Please list the names and relations of family members or other persons, if any, whom we may inform about your child(ren)'s general medical condition and diagnosis (including treatment, payment, and health care operations.) <b>These are the only people who may bring your child to the doctor.</b>	
Please print the address where you would like your billing staten	nents and/or correspondence from our office to be sent.
Please print the primary telephone number where you want to recappointments, lab and x-ray results, or other health care information.  This Release of Information will remain in effect until	ion:
Signature of Parent or Legal Guardian	Date
Print Name of Parent or Legal Guardian	Legal Relation to Child(ren)
Social Security # of Parent or Legal Guardian	Date of Birth of Parent or Legal Guardian
List names of children covered by this form:	
Name:	Date of Birth:/
Name:	
Name:	
Name:	
Name:	
Name:	Date of Birth:/