Name:
DOB:
Chart:
Date:
Age:

Sandhills Pediatrics, Inc. **195 W.Illinois Ave.** **Southern Pines, NC 28387** **Phone 910-692-2444**

Patient Acknowledgement of Receipt of Privacy Notice

Sandhills Pediatrics, Inc is required by the Health Insurance Portability and Accountability (HIPPA) act of 1996 to inform its patients of their rights and duties regarding the privacy of their health information. This policy is posted in the lobby area and is provided to patients at the time of their registration.

I acknowledge that I have received a copy of this notice regarding the use and disclosure of the patient's health information.

______________________________ __________
Signature Date

______________________________ ______________________________
Printed name Relationship to patient

I authorize Sandhills Pediatrics to leave messages regarding my child on voice mail or answering machines at phone numbers I supply. Yes_________ No_______

I specifically authorize Sandhills Pediatrics to release medical information to the following:
(grandparents, nannies, friends)

Name	Relationship	Telephone #

I understand I may change this consent at any time. I release Sandhills Pediatrics, it's employees and physicians for any legal responsibilities or liabilities for disclosure of my child's medical info to the extent authorized here.

______________________________ ________ ____________________
Parent/Guardian Signature Date Relationship to patient

____
Witness