Patient Name: ______________________________ Date of Birth: ____________

18 Years of age and older

Privacy Notice Acknowledgment of Receipt

I, ___________________________, am 18 years of age or older and have
(Please print)

received the Capital Area Pediatrics, Inc. Notice of Privacy Practice. I have been informed that should I have questions regarding Capital Area Pediatrics, Inc. Privacy Policy or do not understand information in the Notice that I may direct these questions to the applicable Office Manager.

___________________________Date Date of Birth___________________________
Patient Signature

Authorization to disclose general medical information to parent or guardian:

I, _________________________authorize Capital Area Pediatrics to share billing, insurance information, and general medical information (routine labs, prescriptions, immunizations) with:

Name___________________________relationship ______________________
(Mother, Father, Guardian)

Name___________________________relationship ______________________
(Mother, Father, Guardian)

I understand that I may revoke this authorization **in writing** at any time except to the extent that action has been taken in reliance on it. To revoke this authorization, please provide a written statement to the office manager.

This authorization will expire on my 21st birthday.

_____________________________ Date_____________.
Patient Signature