Privacy Notice Acknowledgment of Receipt
18 Years of age and older

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

Patient Cell Phone: _____ Patient Email: _____

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) to individuals listed below:

NOTE: This does not include medical records. All patients **18 years of age and older**, must sign for release of any, or all, of their medical records.

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.

In revoking this authorization, I understand that my account will be separated from the family account. I understand at this time I will become responsible for any services received at Capital Area Pediatrics.

This authorization will expire on my 21st birthday.

_____ Date _____
Patient Signature