Snellville Pediatrics, P.C.

Patient Privacy Act Notice

HIPAA is an acronym for the Health Insurance Portability and Accountability Act of 1996. In compliance with HIPAA, Snellville Pediatrics, P.C. requires the following information to be completed for each child.

Unless authorized on this form, it is our policy *not* to release personally identifiable information on any home, cell, or work phone (including voicemail). Additionally, we require an identifying message on any voicemail that *may* be authorized before we leave personal information. Our office will call to confirm existing appointments, but will follow the above rules should any voicemail need to be left.

Please complete the following sections in order to authorize the ways that we are permitted to release information.

Child's Full Name	**Date of Birth**
_____	_____
_____	_____
_____	_____

I may be reached at the following phone numbers and assume responsibility to notify Snellville Pediatrics, P.C. should this information change:

Home Telephone	_____	**Voicemail:**	**YES**	_____	**NO**	_____
Work Telephone	_____	**Voicemail:**	**YES**	_____	**NO**	_____
Cell Phone	_____	**Voicemail:**	**YES**	_____	**NO**	_____

I, _____ (Relationship to Patient: _____), hereby authorize Snellville Pediatrics, P.C. and staff to fax or mail medical information pertaining to the above listed child(ren) to a referral physician, pharmacy, or hospital and will assume responsibility to notify the office should this information change.

The following people may accompany your child(ren) to our office, discuss your child's medical care, and assume medical decision making in your absence:

Name and Relationship	Contact Phone Number
_____	_____
_____	_____
_____	_____

I have been informed that a copy of Snellville Pediatrics, P.C. Notice of Privacy Practices is posted in the office. A copy will be furnished to me upon my request.

_____	_____	_____
Signature	Relationship to Patient	Date

I authorize Snellville Pediatrics, P.C. to use the above listed information to release my child's information. I assume responsibility to notify the office should any of this information change.

_____	_____	_____
Signature	Relationship to Patient	Date