Notice of Privacy Policies

First Name: _____ Last Name: _____ Birthdate: _____

Date:

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

_____

Signature of parent/guardian