Child's Name ______________________________ Date of Birth ____________________

PRIVACY PRACTICES
COMBINED ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO DISCLOSE HEALTH INFORMATION

Please read before signing The Acknowledgement and Consent

This Acknowledgement of Notice and Consent authorizes Children's HealthCare to use and disclose health information about you or your child for treatment, payment and health operation purposes.

Notice of Privacy Practices: Children's HealthCare has a notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access our protected health information. You may review our current notice prior to singing this acknowledgement and consent.

Amendments: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all Protected Health Information that we maintain, including information created or obtained prior to the date of the effective date of change. You may obtain a revised notice by submitting a request to our Privacy Officer.

How to contact our Privacy Officer:
Mail request to:
Children's HealthCare
1517 Pond Road
Allentown, PA 18104

Phone: 610-395-4444
Fax: 610-366-7886

I have received the Notice of Privacy Policies for Children's HealthCare and authorize them to use and disclose health information about the patient, ______________________________________, for treatment, payment, and healthcare operation purposes consistent with its notice of privacy practices.

____
Signature of Patient or Patient's Personal Representative/Parent/Guardian

____
Printed Name of Person Completing this Form

____
Date

____
Relationship to Patient

Child's Name ______________________________ **Date of Birth** _____________________

It is the policy of Children's HealthCare not to release confidential and/or unauthorized information by the home telephone/answering machine, work telephone, voicemail and/or pager. Information will not be left with an unauthorized person who may answer the phone. Also, when returning calls, no information will be left unless the residence or phone number is identified on the recorded message.

I authorize Children's HealthCare and/or staff to leave medical information pertaining to my care of my child's care by the following methods and will assume responsibility to notify them whenever this information changes:

PLEASE LIST ALL PHONE NUMBER WHERE WE MAY CONTACT YOU AND/OR LEAVE MESSAGES:

Phone Number		Contact	Leave Message
Home Phone	________________________________	☐	☐
Parent Name/Cell	________________________________	☐	☐
Parent Name/Cell	________________________________	☐	☐
Parent Name/Work#	________________________________	☐	☐
Parent Name/Work#	________________________________	☐	☐

#1 Emergency Contact Name/Relationship: ____

Phone Number: _________________________ ☐ ☐

Emergency Contact should be someone other than the parent unless patient is over 18 years of age

#2 Emergency Contact Name/Relationship: ____

Phone Number: _________________________ ☐ ☐

Emergency Contact should be someone other than the parent unless patient is over 18 years of age

Child's Name ______________________________ **Date of Birth ____________________**

*****MUST COMPLETE***I authorize Children's HealthCare to fax medical information and/or referrals to another entity. YES NO* (circle one)**
***By selecting No I understand records/referrals/school notes/forms will need be picked up in the office.**

If you would like medical information to be released to someone other than the parent/guardian, please list the name of authorized person and their relationship to the patient (ie grandparent/step-parent/nanny)

______________________________ ______________________________
Authorized Person **Relationship to Child**

______________________________ ______________________________
Authorized Person **Relationship to Child**

______________________________ ______________________________
Signature of Patient or Patient's Personal Representative/Parent/Guardian Completing Form **Printed Name of Person Completing this Form**

______________________________ ______________________________
Date **Relationship to Patient**