Pediatric Associates
OF DALLAS

ACKNOWLEDGEMENT OF THE RECEIPT OF PEDIATRIC ASSOCIATES OF DALLAS' NOTICE OF HEALTH INFORMATION PRACTICES, OFFICE, AND FINANCIAL POLICIES

The **Health Insurance Portability and Accountability Act** (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care. Pediatric Associates of Dallas is furnishing you with the attached notices, which provides information about how Pediatric Associates of Dallas may use and/or disclose protected health information about you for treatment, payment, healthcare operations and as otherwise allowed by law. You shall also be given a copy of the office and financial policies for Pediatric Associates of Dallas.

By signing this form, you acknowledge that you have received a copy of Pediatric Associates of Dallas' **NOTICE OF PRIVATE HEALTH INFORMATION, OFFICE, AND FINANCIAL PRACTICES AND POLICIES.**

______________________________ ________/________/________
Patient's Name   Patient's Date of Birth

______________________________ ______________________________
Signature of Patient or Legal Guardian   Date

PATIENT PREFERENCE REGARDING COMMUNICATION OF HEALTH INFORMATION

Who to Contact

I hereby give permission to Pediatric Associates of Dallas to disclose and discuss any information related to my **medical and financial condition**(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

Name Relationship	Date of Birth	Phone Numbers
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○ I do NOT wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my **medical condition**(s).

How to Reach Primary Contact (Please check all that apply; this is for the primary contact on the Demographic page.)

_____ OK to leave a message on my HOME PHONE with detailed information.
_____ Leave a message on my home phone with a call-back number only.
_____ OK to leave a message on my WORK PHONE with detailed information.
_____ Leave a message on my work phone with a call-back number only.
_____ OK to leave a message on my CELL PHONE with detailed information.
_____ Leave a message on my cell phone with a call-back number only.

Automated Appointment Reminders (Please check one)

_____ **Call** or leave a message on my primary phone
_____ **Text** information to my primary phone
_____ **E-mail** the information to my preferred email address on file

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

______________________________ ______________________________
Signature of Patient or Legal Guardian   **Date**