GLENDALE PEDIATRICS, A PROFESSIONAL CORPORATION
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PATIENT INFORMATION COMMUNICATION FORM

2018

Child's Name:	Date of Birth:	Home Phone:

Address:	City/State/Zip:

Family Members / Friends Involved in My Care:

Revised Date:	Patient Initials:

❑ Ok to disclose information about my child's care or treatment to any individual who states that they are a family member or friend.

❑ Ok to disclose information about my child's care or treatment to only the following family members or friends (check all that apply):

❑ Mother (Name): _____

❑ Father (Name): _____

❑ Stepmother (Name): _____

❑ Stepfather (Name): _____

❑ Other (specify by name and relationship): _____

❑ Do not disclose information about my child's care or treatment to any individual, regardless of relationship.

Acknowledgement of Receipt of Notice of Privacy Practices:

❑ I have received the Notice of Privacy Practices

Signature: _____ Date: _____
Patient/ Responsible Party

Print Name: _____

Relationship, if other than Patient: ❑ Mother ❑ Father ❑ Legal Guardian ❑ Other: (specify):

❑ Patient refuses, or is unable, to acknowledge receipt of the Notice of Privacy Practices.

Employee Signature: _____ Date: _____