SIMI PEDIATRIC PARTNERS

2950 Sycamore Dr. Ste. # 200

Simi Valley, CA 93065

Receipt of HIPAA Notice of Privacy Practices Acknowledgement Form

I acknowledge that I have I been provided the HIPPA Notice of Privacy Practices for Simi Pediatric Partners. This acknowledgement pertains to myself or my children listed below.

Patients Name: ____

Parent/Patient Name________________________**Signature:**__________________________ **Date:**__________
(If pt over 18) (Please Print)

Patient Confidentiality

Whom do you give permission to seek medical treatment for patient and make medical decisions in parent/guardian absence? With whom other than parent (relative, cartaker) may we share medical information via phone or in person? (ex: lab results, x-ray, culture result). *PLEASE NOTE THIS FORM IS NOT A MEDICAL REORDS RELEASE* if you would like to obtain medical records or have someone else obtain them on your/patients behalf a separate records release form will need to be filled out.

Name:______________________________ Phone:__________________ Relation to patient:______________

Name:______________________________ Phone:__________________ Relation to patient:______________

Name:______________________________ **Phone:**__________________ **Relation to patient:**______________

Where and with whom (parent or guardian) may we leave medical and/or billing information?

Name:__________________________________ Phone #____________________ Relation:_____________

Type of phone (cell, home, work): ____________________

Name:__________________________________ Phone #____________________ Relation:_____________

Type of phone (cell, home, work): ____________________

By providing my telephone number, I authorize Simi Pediatric Partners its affiliates and agents to contact me at number using any means of communication, including, but not limited to, calls placed to my cellular telephone using an automated dialing device, calls using prerecorded messages and/or SMS text messages, regarding an current or future loans owned or serviced by Simi Pediatric Partners, its affiliates and agents, even if I will be charged by my service provider(s) for receiving such communications.

Parent/Patient Signature:____ **Date:** ______________________

Print Name:______________________________ **Relation to patient:**______________________________