Summit Pediatric Associates, P.A.
ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE &
DESIGNATION OF DISCLOSURE FORM

1. Acknowledgement of Privacy Practice Notice

I have received a copy of *Summit Pediatric Associates, PA* Notice of Privacy Practices.

_____	_____	_____	
Patient's Name	Date of Birth	Signature of Patient/Parent/Guardian	Date

2. I wish to be contacted in the following manner (check all that apply).

Home Telephone #: _____

____ OK to leave message with detailed information
____ Leave message wit call back number only

Written Communication

____ OK to mail to my home address
____ OK to mail to my work/office
____ OK to fax to this number

Work Telephone #: _____ **Fax #: _____**

____ OK to leave message with detailed information
____ Leave message with call back number only

Email Address: _____

3. **<u>Designation of Certain Relatives, Close Friends & Other Caregivers</u>**

I agree that *Summit Pediatric Associates, P.A.* may disclose certain of my health information to a family member, close personal friend or other caregiver because such person is involved with my health care or payment relating to my health care. In that case, *Summit Pediatric Associates, P.A.* will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of *Summit Pediatric Associates, P.A.* to make the type of disclosure listed above. (I understand that I am not required to list anyone and that I may change this list at any time in writing).

Print Name/Relationship/DOB: _____

Telephone: _____

Print Name/Relationship/DOB: _____

Telephone: _____

Print Name/Relationship/DOB: _____

Telephone: _____

Print Name/Relationship/DOB: _____

Telephone: _____

_____	_____
Signature of Patient/Parent/Guardian	Date