Oak Tree Pediatrics and More

WITH WHOM MAY WE SHARE INFORMATION

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

THE NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

I acknowledge that I have access to the office NOTICE OF PRIVACY PRACTICES. I further acknowledge that the office NOTICE OF PRIVACY PRACTICES is available for review at the front desk upon request, or on the office website at oaktreepediatricsandmore.com

Who may we share medical Information with?

Spouse: _____ Phone: _____

Parent: _____ Phone: _____

Other (Please specify): _____ Phone: _____

Where may we leave a message regarding medical information?

Home answering machine ……. Phone: _____

Office voicemail …… Phone: _____

Cell Phone …….. Phone: _____

Other (please specify) …… Phone: _____

Patient Name: _____

Patient (if over 18) or parent/guardian signature:_____

Relationship to patient: _____

Date: _____