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PRIVACY PRACTICES ACKNOWLEDGEMENT

♦ By my signature below, I hereby acknowledge that I have received a copy of Walden Pond Pediatrics, PC's Notice of Privacy Practices and/or I have been provided an opportunity to review it.

CONSENT TO DISCLOSE HEALTH INFORMATION FOR PAYMENT, TREATMENT, AND HEALTH CARE OPERATIONS (TPO)

♦ By my signature below, I hereby authorize Walden Pond Pediatrics, PC to disclose my medical information so that Walden Pond Pediatrics, PC may treat me, seek payment from third parties for such treatment, and generally carry on Walden Pond Pediatrics, PC's health care operations (e.g. quality assurance). I also authorize Walden Pond Pediatrics, PC to disclose my medical information to insurers and providers outside of Walden Pond Pediatrics, PC when necessary so that these providers may treat me, seek payment for that treatment, and for the purpose of their health care operations.

♦ I agree that telephone messages regarding my appointments, prescription renewals, lab results, and all other Protected Health Information* ("PHI"), may be left for me on voicemail systems and answering machines at the following telephone numbers, in addition to any other numbers provided to you by me:

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other: _______________

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other: _______________

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other: _______________

[If we need to contact you with lab results, please place a check mark next to the preferred contact number, if any.]

♦ I understand that I can change any of the foregoing agreements, at any time, by giving written notice to Walden Pond Pediatrics, PC.

**as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time ("HIPAA")*

Patient Name (print):____

Signature: ____ Date: _________________________

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): ___________________ Relationship to Patient: _____________________