

**Pediatric Partners of Stafford**

**HIPAA Notice of Privacy Practice and Medical Treatment Authorization**

Would you like to authorize anyone other than yourself to receive your child's health information? For example lab or test results, advice from a nurse, or general information. If so, please list who may receive this information (Please list anyone other than yourself). This may include your spouse, parent, guardian, nanny, babysitter, friend, neighbor, or family relative). This person may also bring your child to an appointment in the event of your absence. **Please note information may not be given to parents if patient is 18 years or older, unless given consent below.**

\_\_\_\_\_  
**Patient's Name**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Patient

**Acknowledgement of Receipt of Notice of Privacy and Medical Treatment Authorization**

The practice listed above reserves the right to modify the privacy practices outlined in the notice.

**Signature**

I have received or have been offered a copy of the Notice of Privacy Practices for the practice listed above. In the event of my absence, I hereby authorize the contacts above to bring the above named minor to an appointment and to give consent to any medical diagnosis or treatment for my child that is deemed advisable by any physician or nurse practitioner at Pediatric Partners of Stafford. I certify that I have legal custody of the above named minor and are either the parent or legal guardian.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient Representative

(Required if patient is a minor or an adult who is unable to sign this form)

\_\_\_\_\_  
Relationship of Patient Representative to Patient