Privacy Practices Acknowledgement and Receipt

Due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following information must be completed and updated annually by the patient or guardian:

In the event a family member or caregiver attends my office visits and is in the exam room at the time of my evaluation and/or treatment, I give Child Neurology Consultants of Austin and its providers and employees my permission to discuss freely my condition, treatment or diagnosis with that person present.

(Circle one) YES NO

Notice of Privacy Practice:

By signing below, I acknowledge that I have been provided a copy of this facility's Notice of Privacy Practices Form (Rev. 06/16) for review and a personal copy to keep will be provided upon request.

Signature of Patient or Guardian: ______________________________ **Today's Date:** __________

Relationship to Patient: ______________________________________ (i.e., Self, Parent)

Personal Health Information Release (PHI)

This information must be completed and updated every 6 months by the patient or guardian

This release authorizes Child Neurology Consultants of Austin to discuss medical information regarding my care, condition, treatment or diagnosis with the following:

☐ **Patient Only**

☐ **Spouse (*Specify Name of Spouse):*** ____

☐ **Parent(s) (*Specify Name of Parent(s)*):** ____

☐ **Other *(Please specify)*:** ____

How may we contact you with automated messaging?

Health Notifications	☐ Phone	☐ Email	☐ Text
Appointments	☐ Phone	☐ Email	☐ Text
Announcements	☐ Phone	☐ Email	☐ Text
Billing	☐ Phone	☐ Email	☐ Text

When contacting you with results such as labs, x-rays, etc., please mark one or all desired:

☐ Home Phone: ___________________ May we leave a detailed message: **YES / NO**

☐ Work Phone: ____________________ May we leave a detailed message: **YES / NO**

☐ Cell Phone: _____________________ May we leave a detailed message: **YES / NO**

The following people may pick up medication samples and/or prescriptions on my behalf:

☐ **Patient Only**

☐ **Spouse (*Specify Name of Spouse):*** ____

☐ **Parent(s) (*Specify Name of Parent(s)*):** ______________________________________

☐ **Other *(Please specify)*:** ____

Signature of Patient or Parent/Guardian: ______________________________ **Today's Date:** __________

Relationship to Patient: ______________________________________ (i.e., Self, Parent)

Patient Name: ______________________________ Date of Birth: __________ (Please Print)