



Acknowledgment of Receipt of Notice of Privacy Practices:

_____ I have reviewed this office's Notice of Privacy Practices, which explains how my
initial child(ren)'s medical information will be used and disclosed. I understand that I am
entitled to receive a copy of this document.

Patient Privacy Questionnaire:

I. Please list the family members or other persons, if any, whom we may inform about your child/children's general medical condition and diagnosis (including treatment, payment, and health care operations:)

II. Please list the family members or other persons, if any, who have your permission to bring your child/children to Oak Park Pediatrics Ltd:

III. May we send confidential messages to your email address(es) on file?
____ Yes ____ No

IV. May we send office related information to your email address(es) on file?
____ Yes ____ No

Signature of Parent or Legal Guardian

Date

Print Name of Parent or Legal Guardian

Legal relation to child(ren)

List Name(s) of child(ren) covered by this form:
