Acknowledgement of Notice of Privacy Practices:

I have been presented with a copy of the Notice of Privacy Practices for Patience Pediatrics, Edward W. Lenard, MD, detailing how my information may be used and disclosed as permitted under federal and state law.

Signature:____Date:_____________________

If not signed by patient, please indicate relationship to patient (i.e. mother, father, guardian) and patient name.

Patient Name:___________________________________Relationship______________________

Patient Name:___________________________________Relationship______________________

Patient Name:___________________________________Relationship______________________

Patient Name:___________________________________Relationship______________________

Permission to Leave Messages

By signing below, I authorize Patience Pediatrics to leave non-clinical messages in reference to any items that assist in carrying out my child's/ children's healthcare.

Home Phone:____Yes_____No Work Phone:____Yes_____No

Cell Phone:____Yes_____No Preferred:____Home_____Cell____Work

Permission to send email, if so, email address:

____

Preferred time of day for messages:____Morning____Afternoon ____Evening

Signature:____Date:______________________