Ashe Pediatrics

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Privacy Practices Acknowledgment of HIPAA

Release of Records to Designated Individuals

Patient's Name: _____

Date of Birth: _____

My signature below states I have read the posted Notice of Privacy Practices and can obtain a copy, per my request.

By signing this release, I am giving Ashe Pediatrics permission to release any of my or my child's protected health information, including but not limited to, medical, social and personal history, problems and symptoms, examination and test results, diagnoses and treatment to the below named individual(s)

If anyone other than yourself will be bringing your child to this office, please list their name and relationship (grandparent, aunt, uncle, friend, etc) to the patient.

Name (First, Last)	Relation	Contact Number

I am giving Ashe Pediatrics permission to leave a phone message for me or my child regarding upcoming appointment or a message to return their call.

Yes _____ No _____

Patient/Parent's Signature: _____

Signed: _____ _____

(specify relationship if other than patient:

Parent or Legal Guardian)

Date: _____

Witness: _____

03/2016