Patient Information
Lucedale Pediatrics

Patient #1 Name _____ DOB _____

SSN _____ SEX _____

Insurance _____& #_____

Patient #2 Name _____ DOB _____

SSN _____ SEX _____

Insurance _____& #_____

Patient #3 Name _____ DOB _____

SSN _____ SEX _____

Insurance _____& #_____

Address _____

_____

Phone number
Mother Cell_____

Father Cell _____

Other (Home or work)_____

Parent's email
Mother _____ Father _____

Preferred Pharmacy _____

Mother's Name _____ DOB _____

SSN _____

Father's Name _____ DOB _____

SSN _____

Parent/Guardian Signature: _____ Date: _____

Acknowledgement of Notice of Privacy (HIPPA) and
Consent to Use/Disclose Health Information

I acknowledge that I have received a copy of Lucedale Pediatrics Notice of Privacy Practices. I understand that as part of my healthcare, Lucedale Pediatrics originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care
- A means of which insurance companies can certify that services billed were actually provided
- A source of information for applying my diagnosis and surgical information to my bill
- A tool for routine health care operations, such as assessing quality and reviewing the competence of the healthcare professionals

Before signing this form, you should understand the following:

- By signing this form, I authorize the use and/or disclosure of my protected health information
- I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy regulations, then such information may be re-disclosed and would no longer be protected
- I authorize the release of any medical or other information necessary to process the insurance claim resulting from this service. I also request payment of government benefits either to myself or to the party who accepts assignment below.
- I understand that I have a right to revoke this authorization at any time. My revocation use be in writing. I am aware that my revocation is not effective to the extent that persons I have authorized to use and / or disclose my protected health information have acted in reliance upon this authorization.
- I understand that I do have the right to inspect and copy my own protected health information to be used or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R. Section 164.524).
- I give consent to Lucedale Pediatrics to examine and treat my child as deemed appropriate by the Providers for the period 01/01/2021 - 12/31/2021.
- The following parents/guardians/representatives are allowed to bring my child to Lucedale Pediatrics:

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

Patient, Parent, Guardian, or Representative Signature — Date

Patient Name — Date of Birth