

Galloway Pediatrics, LLC
Edwin Lopez-Bernard, M.D.
53 W. White Horse Pike, Suite D
Galloway, NJ 08205

Notice of Privacy Patient Acknowledgement and Authorization

1. I acknowledge that the Notice of Privacy for Galloway Pediatrics, LLC, was made available to me through the Galloway Pediatrics, LLC website.
2. I consent to the use or disclosure of my protected health information for the purpose of diagnosing or providing treatment to me and obtaining payment for my health care.
3. I may be contacted by telephone at the following numbers. Messages to return the office call and appointment reminders can be left at these numbers. (Personal Health Information such as test results CANNOT be left on an answering machine. Personal Health Information can only be shared with other people authorized by the patient.)

Home # _____ Work # _____

Cell # _____ Fax # _____

4. I authorized the following people to receive my Personal Health (i.e. test results, prescription information, information about appointments with specialists and for diagnostic testing, treatment plan, hospital care, and / or in case of an emergency)

Name _____ Relationship _____ # _____

Name _____ Relationship _____ # _____

This acknowledgement and authorization will remain in effect from this date until I request in writing that it be amended.

Signature of Patient or Guardian

Date

List EACH Patient to be covered by this form:

Print Patient Name and DOB

Print Patient Name and DOB

Print patient Name and DOB

Print Patient Name and DOB

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date _____ Initials _____ Reason _____