A 2 Z PEDIATRICS
550 E. Boughton Rd. Ste. 110
Bolingbrook, IL 60440
(630) 755-5437(KIDS)

RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES FORM
And Consent to Leave Detailed Messages

I, ____, hereby give my consent to A2Z Pediatrics Med-Peds Specialists, PC. to use or disclose, for the purpose of carrying out treatment, payment of health care operations, all information contained in the patient record of

____

(Patient's Name)

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand the physician has a right to change his privacy practices that are described in the Notice. I also understand that a copy of the revised Notice will be provided to me or made available at my request.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

The following person (s) can inquire, pick up records, prescriptions, etc., and take messages regarding my health information.

1. ____ Relationship: ________________
2. ____ Relationship: ________________
3. ____ Relationship: ________________

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At A2Z Pediatrics, we understand that communication is an important part of the patient/health care provider relationship. In order to relay important information to our patients in a timely manner, we many often need to leave messages on voice mails, answering machines or with family members.

In some cases, we are unable to speak with you directly, we may need to leave a voice mail or answering machine message with detailed information about your condition or treatment (such as the results of tests or the scheduling of procedures). You should be aware that other individuals who have access to your voice mail or answering machine could hear these messages. At home this may mean that other members of your family could hear these messages. At work it may mean that your employer could hear these messages.

Please provide the numbers where may contact you:

______________________	______________________	______________________
(Home)	(Mother Work)	(Mother Cell Phone)
______________________	______________________	______________________
(Father Work)	(Father Cell Phone)	(Other Family Member)

Please tell us which numbers we MAY leave a DETAILED message:
☐Home ☐Work ☐Cell
☐None, do NOT leave detailed message on voicemail or answering machine

We may also need to leave messages with detailed information about your condition or treatment, such as the results of tests or the scheduling of procedures with family members or others who answers your home telephone.

☐Yes, you may leave <u>DETAILED MESSAGES</u> with anyone who answers my home telephone

☐No, please <u>DO NOT</u> leave <u>DETAILED MESSAGES</u> with anyone who answers my home telephone.

My signature below indicates I have read and understand the above notice regarding HIPAA consent and consent to leave detailed messages.

____________________________	____________________________	________________
(Print Name)	(Signature)	(Date)