Individual Notice of Privacy Practices Acknowledgement

I acknowledge that I received a copy of CHI/Memorial Health Partners Foundation Notice of Privacy Practices (v03/2016) for my minor child, _____ (print patient's name).

Patient's DOB: _____ _____

Parent Signature

_____

Personal Representative's Signature (If parent/legal guardian is not present)

Individual (or patient representative/parent/legal guardian) did not sign the acknowledgement for the following reason (check below):

_____ Parent/guardian refused

_____ Parent/guardian refused, stating that he/she has already signed an acknowledgement

_____ There was not a personal representative of the individual available to sign.

_____ _____

Witness Signature Date

Personal Representative of Patient

As a parent you may designate one or more personal representatives. A personal representative may receive protected health information (PHI) about your child and you authorize the person(s) to bring my child for treatment or to receive PHI. PHI includes medical conditions and diagnosis, treatment and prognosis, test results, call backs, appointments, etc., regarding my child via telephone in my absence, billing and payments. You can remove or add personal representatives at any time.

_____ I (parent/guardian) do not wish to designate a personal representative.

_____ I (parent/guardian) designate the following as my child's personal representative(s):

_____	_____	_____
Name of Personal Representative	Relationship	Phone
_____	_____	_____
Name of Personal Representative	Relationship	Phone
_____	_____	_____
Name of Personal Representative	Relationship	Phone
_____	_____	_____
Name of Personal Representative	Relationship	Phone

_____ _____

Witness Signature Date

Consent for Telephone Communication

I consent to receive telephone calls from Memorial Health Partners Foundation (MHPF) or a designated third party relating to my healthcare and other services. I agree to receive telephone calls at either my home telephone or my cellular telephone. I agree to allow MHPF to call my home or cellular telephone for purposes related to my care, to provide information about service offerings provided by MHPF, or for quality related surveys or communications related to my care. I understand that calls may be either live in-person calls or automated prerecorded communications. I understand that cellular service charges may apply. I understand that my consent to receive telephone calls is not a condition of my treatment.

_____ _____

Home Phone Mobile Phone

_____ _____

Signature of Witness Date