Kids R Great Pediatrics

303 Scribner Dr. Suite 100

New Albany, In. 47150

(812) 949-1616

Fax: (812) 945-8365

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES RELEASE OF INFORMATION AUTHORIZATION

I, ______________________________, give authorization to Kids R Great Pediatrics, in accordance with the HIPPA guidelines, to discuss my medical information with following individuals. I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the practice as described in the notice.

Name(s)	*Relationship*	*Phone #*

Patient/Patient Representative Signature *Date*

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Patient's Name (please print) ___________________________ *Patient's DOB* ____________________