PEDIATRIC EPILEPSY & NEUROLOGY SPECIALISTS

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Pediatric Epilepsy and Neurology Specialists' Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice and I request the following restriction(s), concerning the use of my personal medical information:

_____

_____

Further, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____ Date: _____

If not signed by the patient, please indicate relationship to the patient (ex. Mother/Father)

Relationship: _____

Office Use Only:

<u>If the patient or legal guardian refuses to sign, indicate your attempt to obtain a signature below.</u>

☐ Patient refused to sign this Acknowledgement

Date: _____Time: _____ Employee Name:_____

Release For Individuals Involved in Patient Care
18-Year-Old Consent Form

I, _____(patient name), give Pediatric Epilepsy and Neurology Specialists (PENS) permission to speak with the following persons regarding my health status, including diagnosis, treatment options, plans and payment for the health services from PENS.

This consent is valid until such time as I provide PENS written revocation.

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Signature: _____ Date:_____