Kangos Pediatrics

12411 Hymeadow Drive, Suite 3F Austin, TX 78750 Phone: (512) 250-1997 Fax: (512) 250-1529

ACKNOWLEDGEMENT FORM

_____ _____

Printed name of Patient Date of Birth

ASSIGNMENT OF BENEFITS

I request payment of the medical benefits, otherwise payable to me, directly to Kangos Pediatrics for services provided by them.

RELEASE OF MEDICAL INFORMATION

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original.

_____ _____ _____

Signature of Parent or Guardian Date Relationship to Patient

HIPAA Notice of Privacy Practices
ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS

By signing below, you acknowledge that you have received the Notice of Privacy Practices prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

SIGNATURE:

Patient/Legal Representative: _____Date:_____

If Legal Representative, relationship to Patient: _____