

I have been given a copy of the Fayetteville Children's Clinic, P.A. Notice of Privacy Practices, version effective January 22, 2021. I consent to the uses and disclosures of my health information as outlined in the Notice.

Signature of Patient or Representative _____ Date _____

Print Name _____

Relationship of Representative to Patient _____

Please describe the Representative's authority to act on behalf of Patient:

FOR FAYETTEVILLE CHILDREN'S CLINIC, P.A. USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:
