PATIENT ACKNOWLEDGMENT AND CONSENT

I have been given a copy of Blue Ridge Pediatrics, LLP's Notice of Privacy Practices effective_____. I consent to the uses and disclosures of my child's health information as outlined in the notice.

_____
Patient's Name

_____ _____
Signature of Patient or Representative Date

_____ _____
Print Name Relationship to Patient

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

_____

MEDICAL ACCESS

Medical History Access-Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

By signing this consent form, you are agreeing that Blue Ridge Pediatrics, LLP can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

_____ _____
Signature of Patient or Representative Date

FOR BLUE RIDGE PEDIATRICS' 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:

_____

_____