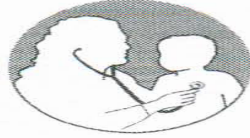

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____
Signature of Patient or Personal Representative

____
Date

____
Name of Patient or Personal Representative

____
Description of Personal Representative's Authority

Parental Preauthorization For Minors

I request and authorize Dr. Olga Gomez Children's Clinic and its personnel to deliver medical care to the child listed below:

Child Name ______________________________ **Date of Birth**_________________________

____
Parent's Signature

Acknowledgement of Review of Financial Policy

I have read and understand Dr. Olga Gomez Children's Clinic Financial Policy and understand that payment is due at the time services are rendered.

____
Signature of Patient or Personal Representative