WESTFIELD PEDIATRICS, P.A.

ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE AND DESIGNATION OF DISCLOSURE

Acknowledgment of Privacy Practice Notice
I have received a copy of Westfield Pediatrics, P.A.'s Notice of Privacy Practices.

_____	_____	_____	_____
Patient's Name	Date of Birth	Parent/Patient/Guardian Signature	Date

Designation of Certain Relatives, Close Friends, and other Caregivers

I agree that Westfield Pediatrics, P.A. may disclose certain of my health information to a family member, close friend, or other caregiver because such person is involved with my health care or payment relating to my health care. In that case, Westfield Pediatrics, P.A. will ***disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.***

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of Westfield Pediatrics, P.A. making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

_____	_____
Print Name	Date of Birth
_____	_____
Print Name	Date of Birth
_____	_____
Print Name	Date of Birth
_____	_____
Print Name	Date of Birth
_____	_____
Signature Patient/Parent/Guardian	Date