My signature indicates that I have been provided with a copy of the Raynham-Taunton Pediatrics privacy practices. Also, I allow this practice, upon my written or verbal request, to disclose protected health information for school forms, athletics forms, camp forms and work forms.

Patient Name (Please Print) Date

Signature of Parent of Patient, or Patient, or Legal representative.

If signed by legal representative, relationship to patient.

If signature is for more than one child, please write additional names.

Please list anyone who has your permission to bring your child to our office for medical care in your absence and/or who is authorized to receive your child's medical information. In the event of an emergency, only people you authorize in writing, per HIPAA requirements, will be able to accompany your child for treatment without you being present.