

**Drs. G. Lee Lerch & Christopher Amato & Associates
Pediatric & Adolescent Medicine**

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Dear Patient:

Please be advised that we are required by law to maintain the privacy of, and provide individuals with, notice of our legal duties and privacy practices with respect to protect health information. If you have any objection to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practice:

Signature:

Date: _____

Print Name: _____

In accordance with the federal regulations regarding patients' privacy, please read and sign the following:

I, _____ give permission to Drs. Lerch, Amato & Associates to do the following:

Confirm appointments by phone

Leave message on answering machine confirming appointments

Release medical information requested by another treating physician or health institution

Give permission for Drs. Lerch, Amato & Associates to request records as needed from other physicians and/or institutions to assist in my ongoing treatment.

The following person is authorized to receive medical information and/or bring in my child for a visit and make medical decisions on my child's behalf, who is the patient, in the event that I cannot be available:

Contact Name: _____ *Phone#:* _____

Relationship of Contact: _____

Patient Signature: _____

Date: _____