PAK PEDIATRICS

NEPA BREASTFEEDING CENTER

Patient Name:_____ Date of Birth:___/___/_____

HIPAA

*****MUST COMPLETE AUTHORIZED INDIVIDUALS SECTION FOR PRIVACY *****

Additional Authorized Individuals/Contacts (other than custodians)

The individuals identified below are authorized to accompany, provide consent for treatment, and or receive protected health information about the pediatric patient.

First	Last	Relationship	Phone Number
First	Last	Relationship	Phone Number
First	Last	Relationship	Phone Number

_____I understand that an authorized individual must present a valid photo ID at the visit.
(Initial)

_____ Date _____
Parent/Guardian Signature