Ridgefield Pediatric Associates, P.C.

38 B Grove Street, Ridgefield, CT 06877 • (203) 438-9557 • Fax (203) 438-6456 • www.ridgefieldpediatrics.com

HIPPA Consent Form

I, ______________________________ authorize Ridgefield Pediatric Associates, P.C. to discuss all my medical information (ex: office visits, lab results and physicals) from date of birth to the age of 22 years old.

Signature____ Date______________________

If you would like a date different from above please specify___________________________________.

If there is information you would like us **NOT** to discuss pertaining to medical health please specify below: (ex: Pregnancy test, STD testing or mental health issues)

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Feel free to discuss my medical information with:

Name______________________________ Relationship to Patient_________________________

Name______________________________ Relationship to Patient_________________________

I understand that Ridgefield Pediatrics Associates P.C., will adhere to the regulations as outlined by HIPPA and will follow the guidelines I have outlined above.

Signature____ Date______________________

I **DO NOT** give permission for Ridgefield Pediatric Associates, P.C., to discuss any of my medical information with anyone other than myself.

Sgnature____ Date______________________

Best contact # to reach you?____