Milestones Pediatrics, LLC
11 East Oak Street Oakland, NJ 070436
ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE,
RELEASE OF PRESCRIPTION HISTORY AND DESIGNATION OF DISCLOSURE

PATIENT'S NAME DATE OF BIRTH

PATIENT'S NAME DATE OF BIRTH

PATIENT'S NAME DATE OF BIRTH

PATIENT'S NAME DATE OF BIRTH

PATIENT'S NAME DATE OF BIRTH

PATIENT'S NAME DATE OF BIRTH

Designation of Certain Relatives, Close Friends and other caregivers

In the event that I am not available to bring my child/children in for medical treatment/care, I agree that Milestones Pediatrics, LLC has my authorization to treat and disclose medical information regarding my child's health to a family member, close personal friend or another caregiver (**NOT MOM & DAD)** Example: (Aunts, Uncles, Grandparents or neighbor). I designate the person(s) listed below as those individual(s). I understand that I am not required to list anyone. I also understand that I may change this list at any time by submitting a written request to Milestones Pediatrics, LLC.

Print Name:______________________________Relationship:______________________________

Print Name:______________________________Relationship:______________________________

Print Name:______________________________Relationship:______________________________

Signature of Parent or Legal Representative Print Name Date

Acknowledgement of Privacy Practice Notice

I have reviewed a copy of Milestones Pediatrics, LLC's Notice of Privacy Practices. I hereby consent to the use or disclosure of my protected health information by, or on behalf of, Milestones Pediatrics, LLC for purposes of treatment, payment or healthcare operations. I understand that my protected health information may be used for such purposes.

I also recognize that it is my responsibility to arrange to have my child's previous medical records, if applicable, forwarded to Milestones Pediatrics, LLC.

Signature of Patient or Legal Representative Print Name Date

Consent to Release Prescription History

I agree to allow Milestones Pediatrics, LLC to view my prescription history from external sources and discuss medication for the purpose of obtaining authorization.

Signature of Patient or Legal Representative Print Name Date