

PATIENTS NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

### Notice of Privacy/No Show Policy Acknowledgement

I, \_\_\_\_\_, acknowledge that I have received from Illini Pediatrics, LLC a copy of their Privacy Notice, Immunization Policy, No Show Policy (rev 08/11/2010), and Billing Policy. I understand it is my responsibility to read the notices and ask questions as necessary. I am also aware that I am responsible for all collection agency fees, as well as court costs and attorney fees, in the event of litigation, if my account is sent to collections for non-payment.

 \_\_\_\_\_  
 Patient Signature/Patient Representative

 \_\_\_\_\_  
 Date

 \_\_\_\_\_  
 Relationship to Patient

 \_\_\_\_\_  
 Witness

 \_\_\_\_\_  
 Date

### CONSENT FOR RELEASE OF INFORMATION TO DESIGNATED FAMILY MEMBERS OR CAREGIVER.

The Undersigned consent to Illini Pediatrics, LLC releasing his/her medical information to:

 \_\_\_\_\_  
 Name to Receive Info & Relationship to Patient

 \_\_\_\_\_  
 Name to Receive Info & Relationship to Patient

 \_\_\_\_\_  
 Name to Receive Info & Relationship to Patient

This consent remains in effect for a one (1) year period (as signed by the designee.) This form must be resigned at the year's expiration. This consent may be revoked at any time upon written request.

Signed \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_

City/State \_\_\_\_\_

Phone \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_\_