JUST KIDS DIAGNOSTIC & TREATMENT CENTER, INC.
LONGWOOD HIGH SCHOOL
SCHOOL- BASED HEALTH CENTER
35 Longwood Rd, P.O. Box 12
Middle Island, NY 11953

Patient's Name: _____ Date of Birth: _____

I hereby give permission to Just Kids Diagnostic & Treatment Center Family Medicine & Pediatrics to discuss with the following individuals information related to the health care services I receive in this office.
I agree that this will include laboratory test results, radiology examination results, billing inquiries.
I agree that this authorization will remain active until I revoke it by submitting an updated authorization to Just Kids Diagnostic & Treatment Center Family Medicine & Pediatrics

Name of Individual: _____ Relationship to Patient: _____
Name of Individual: _____ Relationship to Patient: _____
Name of Individual: _____ Relationship to Patient: _____
Name of Individual: _____ Relationship to Patient: _____

_____ _____
Signature of Parent/Guardian Please Print Patient's Name

_____
Date

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient's Name: _____ Patient's Date of Birth: _____

Parent/Guardian Signature: _____

Date: _____

For Office Use Only
Office Staff Signature: _____ **Date:** _____