OFFICIAL USE ONLY- MRN

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CarolinaEast Pediatrics complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

PATIENT ACKNOWLEDGMENT AND CONSENT

Patient's First Name _____ MI ____ Last Name _____ Birth Date _____

Initial here if no one is allowed to obtain your medical information: _____ **-OR-**

The following individuals have my permission to obtain my medical information:

Print Full Name	Birth Date	Telephone	Relationship

By signing this document, I confirm that I, the Patient or legal representative, have been provided with the CarolinaEast Health System Notice of Privacy Practices, effective October 31, 2019, and also agree to the information listed above. I consent to the uses and disclosures of my health information as outlined in the Notice and this Acknowledgment.

Signature of Patient/Guardian _____ Date _____

Guardian's Print Name _____ Guardian's Birth Date _____

Signature of CarolinaEast Physician's Witness* _____ Witness' Print Name _____

*Witness will indicate the representative's authority to act on behalf of the Patient by checking the applicable item below:

- ☐ Parent or legal Guardian of the above minor.
- ☐ Legal Guardian of an adult Patient who has been adjudicated incompetent.
- ☐ Acting under a Durable Power of Attorney for Health Care for the Patient.
- ☐ Other: _____

*I have confirmed that the above Representative is 1) the parent or legal guardian of the Patient who is a minor, or 2) acting under a North Carolina Durable Power of Attorney for Health Care for the Patient and has presented the official document in proof or is Guardian of the Person or General Guardian (Guardian of the Estate is not valid for healthcare) and presented an official Letter of Appointment where he/she is named as such in proof. A copy of the official document will be retained in the Patient's electronic health record.