

Barton Creek Pediatrics

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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Name of Patient

Signature of Patient or Parent Representative

Relationship to Patient

Date _____

Contact Permission

In the event that Barton Creek Pediatrics needs to contact you regarding an appointment, lab results, medication, or to provide copies of the medical record, upon my request, it is permissible to:

Check all that apply:

- Leave a message on an answering machine/cell phone voicemail.
- Speak with nanny/caregiver.
- Speak with other family members.
- Email records. I authorize Barton Creek Pediatrics to email medical records to my personal email. I acknowledge the risks involved with using an unsecured delivery method and accept responsibility for any breach of confidentiality.

Signature of Parent/Parent Representative

Date