



Authorization and Acknowledgement

Patient Name: _____ Date of Birth: _____

Authorization For Treatment:

I hereby authorize First Steps Pediatrics & Adolescent Medicine, P.L.L.C. to administer such treatment and perform such procedures as may be deemed necessary or advisable in the diagnosis and ongoing medical care of this patient.

Acknowledgement of Notice of Privacy Practices:

I acknowledge that I have reviewed/received a copy of the Notice of Privacy Practices. I understand that information the Physician Practice above acquires or creates about me will only be disclosed to others for treatment, payment, and health care operations as set forth in the Notice or as authorized by me in writing. Any restrictions on the release of my health information are to be noted on the separate Patient Confidentiality Form provided by the office staff upon request.

I certify that I have read this form and that I understand its contents.

X _____
(Signature of patient or responsible party/Relationship)

Date: _____

(Social Security Number)