Kid's Way Pediatrics
Dr. Cheryl A. Duffy, MD, FAAP
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Acknowledgement

This is to certify that I, the undersigned, hereby consent to and authorize the disclosure of any medical information to the following: (please circle)

Father Mother Sibling Grandparent Husband Wife

Other: (please specify)

May we leave a message at the contact number you provided?
Yes No

May you be called at your place of employment to be informed of any medical information?
Yes No

If you do not want a certain disclosure made to the above, it is your responsibility to notify us.

I hereby acknowledge receipt of the Notice of Privacy Practices.

Signature	Date	Witness	Date
Signature	Date	Witness	Date
Signature	Date	Witness	Date