APC PEDIATRICS

Privacy Notice/Consent Form

As our patient in APC Pediatrics we value you and your child Privacy. We will not disclose any information to anyone regarding your child health without your consent. We are asking all parents to sign this consent/ privacy form so we will be able to order necessary test, do referrals, discuss your child medical treatment with other physicians as necessary as well as bill your insurance company. At anytime you may withdraw your consent, by giving us a written statement stating that you are withdrawing your consent. No information will be given to anyone for marketing, fund raising or anything else not related to medical care.
If you have any concerns, please let us know and we will try to answer your concerns. Any questions or concerns should be addressed to our administrator.
Thank you
Federico Frias MD

By signing below, represents my understanding and willingness to comply with this policy. I acknowledge I have read and received a copy of the above form.

Signature of Parent or Guardian _____Date_____

Child name _____ Birthday _____

Witness _____

Rev-8/07

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APC Pediatrics – Federico Frias MD, FAAP

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