

**MURRAY PEDIATRICS**  
**Pediatrics**  
**164 East 5900 South, Ste #112**  
**Murray, UT 84107**  
**Phone: 801-262-2673 Fax: 801-269-9894**

**HIPAA ACKNOWLEDGEMENT**

I hereby acknowledge that I have had the opportunity to review and/or receive a copy of HIPAA Notice of Privacy Practices for Murray Pediatrics.

**AUTHORIZATION**

My signature below authorizes the staff of Murray Pediatrics to verbally (by telephone or in person) share all of my medical information without limitation with the following individuals:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This form does not entitle these persons to copies of medical records. Consent expires with the end of my care with Murray Pediatrics.