Pediatrics of Steamboat Springs

940 Central Park Dr. Ste. 201 Steamboat Springs, CO 80487
WWW.PEDIATRICSOFSTEAMBOAT.COM

Steamboat Location:
Ph. 970-871-1900 Fx. 970-870-3138

Hayden Location
Ph. 970-276-1900 Fx 970-276-7263

Ronald F. Famiglietti, M.D. Sheila M. Fountain, M.D. Dana M. Fitzgerald, M.D. Abigail Hoffner, RN NP-C

Patients 18yr and Older:

By signing below, the responsible party acknowledges that he or she has read and understood the foregoing Privacy Policy and Financial Policy and agrees to be bound by the terms and conditions set forth therein. You are entitled to your own copy of these documents and may obtain one from the front desk by request.

Patient name: (Please print) _____ **Date:** _____

Patient signature: _____

Health Information Release:

My Authorization:
You may use or disclose all of my health information maintained by the above-named practice to my parents or guardians.

I specifically authorize disclosure of the following conditions (check all that apply):
___ Drug abuse ___ Alcohol abuse ___ HIV/AIDS ___ psychological or psychiatric conditions, including psychotherapy notes

This authorization ends: On (date) _____ or when I turn 21. (please circle one)
I may revoke this authorization in writing. If I revoke this authorization, it would not affect any actions already taken by the above-named practice based upon this authorization. To revoke this authorization, write a letter or email stating your wishes to the Practice Manager (manager@pediatricsofsteamboat.com).

Once the office discloses health information, the person or organization that receives it may be able to redisclose it. Privacy laws may no longer protect it.

Patient name: (Please print) _____ **Date:** _____

Patient signature: _____

For the Patient's Parents:

By signing below, the parent or guardian acknowledges that he or she has read and understood the foregoing Financial Policy and agrees to be bound by the terms and conditions set forth therein. You are entitled to your own copy of these documents and may obtain one from the front desk by request. By signing below, **you are agreeing to be financially responsible for the care of your child while being seen by the providers at Pediatrics of Steamboat Springs.**

Parent/Guardian name: (Please print) _____ **Date:** _____

Parent/Guardian signature: _____