

**Patient Name:** \_\_\_\_\_

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of Technology and Language Center, Inc.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Date

**CONTACT INFORMATION**

*The contact information of the parent or legal guardian who signed this form should be filled in below.*

Address:  
\_\_\_\_\_

Telephone:  
\_\_\_\_\_ (daytime)  
\_\_\_\_\_ (evening)

Individual Authorization