**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