NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that the Department of Health and Human Services has established a "Privacy Rule" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I acknowledge that your Notice of Privacy Practices has provided information to me regarding how you may use and disclose my child's/children's protected health information (PHI). I understand that the information can and will be used and disclosed for treatment, payment and healthcare operations, and that the terms of your notice may change. I also understand that I may request a current copy of your notice any time by contacting the practice.

I have been informed that I am entitled to full access to the personal medical records, and that I may request in writing, certain restrictions as to how this information may be used and disclosed. I do acknowledge that you are not required to agree with my request, but if you do agree, you are bound to abide by my requested restrictions.

I acknowledge that I am in receipt of your Notice of Privacy Practices and have been given the right to review your Notice of Privacy Practices prior to signing this acknowledgement, I agree to the practices' use and disclosure of protected health information regarding my child/children for treatment, payment and healthcare operations.

Patient Name (s) _____

This Acknowledgement was signed by (print name)_____

Signature: _____ Date: _____

Relationship to Patient (s) _____

Witnessed by: _____ (Practice Representative) Date:_____

OFFICE USE

I attempted to obtain a signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____ Practice Representative _____

Reason:

_____

_____