Alliance Pediatrics

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

_____ _____

Name of Patient *Patient's Date of Birth*

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can used by our staff in providing and arranging your medical care.

I am the parent or legal representative of the above-named minor child. I have received a copy of Alliance Pediatrics' Notice of Privacy Practices, and understand that I may view or download such Notice of Privacy Practices on Alliance Pediatrics' website at www.alliance-peds.com.

I understand that Alliance Pediatrics has the right to change their privacy practices and that I may obtain revised notices at the clinic or on the website.

_____ _____

Signature of Parent or Legal Representative *Date*

_____ _____

Printed Name of Parent or Legal Representative *Relationship to Patient*

For office use only:

_____ I certify that I provided or offered to provide a paper copy of Alliance Pediatrics' Notice of Privacy Practices to the above-named individual during a clinic visit on _____ _____. I asked such individual to acknowledge receipt thereof by signing this form, but he or she refused.

_____ I certify that, upon request of the above-named individual, I e-mailed an electronic copy of Alliance Pediatrics' Notice of Privacy Practices to him or her on _____ _____. I asked such individual to acknowledge receipt thereof either by return e-mail or by signing this form at a subsequent clinic visit, but he or she refused.

_____ _____

Signature *Date*

_____ _____

Printed Name *Title*