PINECONE PEDIATRICS

Acknowledgement of Receipt of Notice of Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA), requires us to give you a notice of our privacy practices and to acknowledge your receipt of the notice.

The Notice of Privacy Practices explains how your health information may be used and or disclosed by us. In addition, it explains your rights with regard to your protected health information, as well as our legal responsibilities. You can view the Privacy Practices in one of three manners: we can email you a copy, you can view it on our website, or you may request a paper copy.

I have been provided with access to a copy of the Notice of Privacy Practices in electronic or paper format. I understand that as part of this organizations treatment, payment or health care operations, it may become necessary to disclose my protected health care information to another entity. I hereby consent to such a disclosure for these permitted uses. I also consent to such disclosures via fax.

Patient Name: _____

Parent/Legal Guardian Name (Printed): _____

Parent/Legal Guardian Signature: _____ Date: _____

Please list the names of others with whom you would like to give permission to share your healthcare information (these may include family members or other individuals/entities):

_____

_____

_____

_____

Phone Correspondence

Preferred Contact Phone Number: (_____) _____

May we leave detailed medical information on your home voice mail? _____Yes _____No

May we leave detailed medical information on your cell phone? _____Yes _____No

May we leave detailed medical information on your work voice mail? _____Yes _____No

Mail Correspondence

Please print the address of where you would like any correspondence from our office to be sent if other than your home:

_____