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HIPAA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to make available to you a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. A copy of our current Notice of Privacy Practices is posted in our office and on our website. You are entitled to a copy of our Notice of Privacy Practices. Please sign this form to acknowledge the Notice of Privacy Practices was made available to you. You may refuse to sign this acknowledgement, if you wish.

I am aware that a new Notice of Privacy Practices is in effect as of September 23, 2013. I acknowledge that this copy of Pediatric Care Corner's Notice of Privacy Practices was made available to me.

I further authorize the disclosure of the following protected health information (check box to indicate your authorization):

☐ *Personal photographs with or without names or other identifiable information that you have provided or sent to the office for the purpose of posting on our office bulletin board. I understand that I have the right to revoke this authorization in writing.*

____
Please print patient's name here

____
Signature of parent, patient, or guardian

____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain an acknowledgement.

______________________________ ________________
Employee signature *Date*

______________________________ ________________
Witness signature *Date*