NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my child's treatment and follow up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand the above information above. I also understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.* _____ (Guarantor's initials)

I allow The Children's Clinic, PLLC to provide complete copies of medical records for my child to any medical facility or person providing medical care to the patient. _____(Guarantor's initials)

List any known individuals or medical facility you would like to have access to your child's medical records:

_____ _____
_____ _____
_____ _____

Patient's Name _____ DOB _____

Guarantor's Signature _____ Date _____

Practice Use Only

I attempted to obtain the patient's signature in acknowledgement of the *Notice of Privacy Practices*, but was unable to do so because: _____
_____

Employee's Signature _____ Date _____

COMPLETE OTHER SIDE