Tri-County
PEDIATRICS

HIPAA Acknowledgment Form

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

The Privacy Act requires that you be informed of your rights to patient privacy. In order to demonstrate that you were advised of your right to privacy of your medical records, we ask that you complete the following:

I, _____ (Legal Guardian's Name) am the responsible party for
Child's Name (List All) Date of Birth

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

I am related to the child by _____ (Indicate Relationship).

I have been (**Check one block only**):

1. Offered (but refused to read/sign) (check here) **–or**--,
2. Reviewed (check here), --**or**--
3. Received (for take-home) (check here),

a copy of **Tri-County Pediatric's** Notice of Privacy Practices.

Lab Results:
May we leave your child's lab results on your voicemail? Yes No
If Yes, what telephone number should we leave the results on?_____

Signature:_____Date: _____