The Pediatric Care Center

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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. I hereby acknowledge that The Pediatric Care Center has provided me with a copy of its *Notice of Privacy Practices.* This document describes how medical information about me or my child(ren) may be used and disclosed. It also describes how I may access this information, and the release of information. I understand that The Pediatric Care Center has the right to change its *Notice of Privacy Practices* from time to time and that I may contact The Pediatric Care Center at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

Patient Name: ____

Legal Guardian Name: ______________________________________

Signature: ____

Date: ____________________

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below.

Date:	Employee Name:	___ Patient declined to sign this written acknowledgement ___ Other: Please Specify: