Acknowledgement of Receipt of HIPPA Notice of Privacy Practice

I have received a copy and/ or read the " Notice of Privacy Practices," which explains how my medical information will be used and disclosed. A copy is available upon request.

In effort to comply with the Health Information Privacy Act (HIPPA), we need to be certain that we guard your child's privacy according to your wishes when it comes to your family and friends.

I would like to be contacted via:

Home Phone Number: (_____)_____

Cell Number: (_____)_____

***** E-Mail address: _____@_____.com**

Please circle your response to the following:

May we leave messages concerning your child's appointment with family, friends, or secretary who regularly answers your calls. **Yes No N/A**

May we send text or leave messages on a voicemail at home/ cell phone/ or work phone regarding an appointment, referrals, or text results? **Yes No N/A**

May we share your child's pertinent medial information with specialist that they may be seeing? **Yes No N/A**

May we release forms, prescriptions, or samples to your spouse or family members if they need to pick them up for you? **Yes No N/A**

This office now sends your child's prescriptions electronically to your pharmacy; please provide us with your pharmacy name and number:

Name: _____ Phone# _____

Patient Name: _____ Date: _____

Signature: _____ Relationship to patient: _____