DR SAMUEL Y. BROWN

PEDIATRICS

A Professional Medical Corporation • Pediatrics and Adolescent Medicine
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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

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

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

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I 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 at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

IMPORTANT PRIVACY NOTICE

Privacy regulations require your permission to discuss health issues with others. We may discuss personal health information, such as laboratory results, medications, and treatment, with (please circle):

Spouse Sibling Child Parent Step-parent Grandparent Guardian Other:_____

Please provide phone number(s) and name(s) of 2 individuals whom we may release information to on your behalf:

Note: Only the persons listed in the box below will be allowed to bring your child into Dr. Brown's office.

Name:_____ Relationship _____
Home #_____ Work #_____ Cell #_____
Name:_____ Relationship _____
Home #_____ Work #_____ Cell #_____

Anyone to be excluded: _____ _____

OR ☐ I do not permit any information to be disclosed to anyone but myself.

Signature:_____ Date: _____

Patient Name: _____ Date of Birth _____/_____/_____

Relationship to patient:_____

Signature _____

Date:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on the Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date	Intitials	Reason