Park View Pediatrics
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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:

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

I have received, read and understand your Notice of Privacy Practices. Should I want to review a more complete description of the uses and disclosures of my health information, I understand that detailed Notice of Privacy Practices will be provided for me upon request. I understand this organization has the right to change its Notice of Privacy Practices from time to time that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

4. Park View Pediatrics endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the CORHIO HIE, or cancel an opt-out choice, at any time.

Patient Name (s)

Last Name	First	M.I.	Date of Birth
	First	M.I.	Date of Birth
	First	M.I.	Date of Birth
	First	M.I.	Date of Birth

Relationship to Patient _____

Signature _____ Date _____

OFFICE USE ONLY I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practice Acknowledgement, but was unable to do so as documented below.

Date:_____ Initials: _____ Reason:_____