NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability 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/my children's treatment and follow-up among the physicians of our practice as well as any specialists/physicians outside of our practice involved in the treatment directly or indirectly.
- Obtain payment for the services provided
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received information about Patient Rights and the Notice of Patient Privacy Practices at Children First Pediatrics including who to contact with questions or concerns or formal grievance. I have also received a copy of the **Children's IQ Network** (CIQN) Information Sheet. I understand that patient information will still be stored electronically for my provider's records, and that an electronic health summary will be available to other providers thru the CIQN. I also understand that I have the right to not share (opt out) health information with other providers within the CIQN.

I have received, read and understand your *Notice of Privacy Practices* written in plain language containing a more complete description of the uses and disclosures of my/my children's protected health information. I understand that Children First Pediatrics has the right to change their *Notice of Privacy Practices* at any time and that I may contact the practice at any time to obtain a current copy of this notice. I further understand my individual rights and the process that needs to be taken if I have a complaint or concern about this policy.

I understand that I may request in writing that you restrict how the private information of myself/my children is used or disclosed to carry out treatment, payment and healthcare operations. I also understand you are not required to agree to my requested restrictions.

Patient Name_____ DOB:_____

Relationship to Patient_____

Signature_____ Date:_____

OFFICE USE ONLY

I attempted to obtain a signature in acknowledgement of this Notice of Privacy Practices, but was unable to do so as documented below.

Date:_____ Initials:_____ Reason:_____