Flanders Pediatrics, LLC

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required by state and federal laws, including HIPAA rules to safeguard general and health-related information about you. We have created a Notice of Privacy Practices that explains how your protected health information {PHI}is handled. The Notice of Privacy Practices is provided to patients {or their parent/guardian} when they first join our practice.
We are asking you to sign this form to show that we offered you a copy of our Notice of Privacy Practices. By signing below, you are acknowledging that you were offered or received a copy of the Notice of Privacy Practices from our office.

ACKNOWLEDGEMENT

I acknowledge that Flanders Pediatrics, L.L.C. has offered or provided me with a copy of its Notice of Privacy Practices, which describes how medical information about me may be used or disclosed and how I can access this information.

PATIENT NAME: _____ DOB: _____

AUTHORIZATION TO DISCLOSE PHI

I authorize the following person(s) to access my child's medical record {including picking up prescriptions, bringing my child to appointments and discussing medical information.

_____	_____	_____
Name of authorized representative	Relationship	Phone number
_____	_____	_____
Name of authorized representative	Relationship	Phone number

I understand that I may revoke this authorization in writing at any time. I also understand that I am entitled to receive updates upon request if Flanders Pediatrics, L.L.C amends or changes its Notice of Privacy Practices in any way.

_____	_____
Signature of patient or parent/guardian	Date signed
_____	_____
Printed name of patient or parent/guardian	Relationship to patient

This section to be completed by Flanders Pediatrics, L.L.C. only if unable to obtain a written acknowledgement from the patient/parent/guardian.

Our office has made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above named patient/parent/guardian, but was unable to do so because:

☐ Patient/parent/guardian declined to sign this acknowledgement

☐ Other{specify} _____

Name/title of employee: _____ **Date:** _____

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