

Acknowledgment of Privacy Practices

Bramblebush Pediatrics respects your privacy and only uses or discloses your child(ren)’s medical information when necessary or appropriate. Our Notice of Privacy Practices describes potential uses and disclosures of your health information by our practice and outlines your medical privacy rights. A copy of the Notice of Privacy Practices is available in the office for your review or you may request a copy.

* By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.
* By signing this form, you acknowledge that a copy of our Notice will be made available upon your request
* By signing this form, you acknowledge that you understand the contents of our Notice and how it applies to you.
* By signing this form, you acknowledge that all of your questions regarding the contents of our Notice have been answered.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (Parent/Legal Guardian Name) hereby acknowledge that I was given the opportunity to review or and request a copy of the Notice of Privacy Practices issued by Bramblebush Pediatrics on the date indicated below.

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Parent/Legal Guardian (Please Print)

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Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­

Relationship to Patient(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For office use only:

\_\_\_\_\_ Patient refused or unable to sign

Comments:

REVISED: 09/23/2013