ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Universal Pediatric Associates
422 Worcester Street, Suite 105
Wellesley, MA 02481

In this notice "you" and "your" are also used to mean and pertain to "you" or to "your child" or "your children" where appropriate.

The providers, medical assistants and administrative staff at our practice, at the directions of the physicians, may share your health information for treatment, payment and health care operations.

I understand that my health information may be used for treatment, payment or healthcare operation purposes such as:

1. Sharing my healthcare information among providers (both inside and outside the practice) on a need to know basis, to give me (or my child) treatment.
2. Using my healthcare information for billing purposes, including giving referrals to specialists, when necessary and appropriate.
3. Sharing my health information with health insurance companies, government agencies or other payers that request information related to benefits determinations, claims filed for visits or admissions and other billing matters.
4. Using my health information for healthcare operations, including monitoring the quality of care, audits and surveys and carrying out other business and administrative activities.

I understand that all reasonable efforts will be made to protect the privacy of my health information, whether maintained on paper or electronically, and regardless of how it is communicated (paper, email, fax or mail).

I have been given the opportunity to read Notice of Privacy Practices that outlines in more detail how my health care information is used and shared with other. The Notice of Privacy Practices explains (1) when I need to give further approval for the providers to use my health information or share it outside the practice and (2) when my permission is not needed for the providers to use my health information or share it outside the practice (e.g. required by law, public health activities, etc).

I understand that this practice has reserved the right to change the Notice of Privacy Practices at any time. I may obtain a current copy of the Notice of Privacy Practices by contacting the office.

My signature below constitutes my acknowledgement that I have been given the opportunity and/or have been provided a copy of the Notice of Privacy Practices.

Signature of patient (if over the age of 18) or parent, guardian Date

Print Name