Next Generation
PEDIATRICS

Notice of Privacy Practices Acknowledgement

Patient Name:_____ DOB:_____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding the protected health information of my child. I understand that this information can and will be used to:

- Conduct, plan, and direct treatment and follow-up among the multiple healthcare providers who may be involved in my child's care, directly or indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and provider certifications

I am aware that this medical practice has the right to change its Notice of Privacy Practices as healthcare laws change. These changes will apply to all information that Next Generation Pediatrics about me. The new notice will be available upon request, in our office, and on our web site https://www.nextgenpediatrics.com.

By signing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices and agree to its terms.

_____
Printed Name Parent/Guardian

_____ _____
Signature of Parent/Guardian Date

PRACTICE USE ONLY

I attempted to obtain the parent/guardian signature to acknowledge the receipt of the Notice of Privacy Practices, but was unable to do so as documented below:

Date	Staff Initials	Reason