

PARK PEDIATRICS

ACKNOWLEDGMENT OF PRIVACY PRACTICES

Abbreviated

This is a summary of Notice of Privacy Practice. Read full version to sign acknowledgment.

I understand that, under the Health Insurance Portability Act of 1996 (HIPAA), I have certain rights to privacy regarding my Individually Identifiable Health Information (IIHI).

I understand that this information can and may be used for:

- Treatment
- Payment for treatment or services
- Healthcare operations
- Appointment/Follow-up calls
- Coordinating healthcare care among individuals involved in your or your child(ren)'s care

I understand that my or my child's PHI may be disclosed to outside individuals if:

- Required by court order, law enforcement, and/or public health organizations
- Assisting to prevent or control disease, injury or disability in matters of public health
- Assisting to avert a serious threat to the health or safety of you, or any other person or the public
- Assisting funeral directors, medical examiners or coroners in the event of death
- Assisting in organ/tissue donations if your child is an organ donor
- For approved research purposes; patient identification will only be released with your permission
- Required by federal officials in matters of national security
- Recommending possible treatment alternatives
- Complying with Workers' Compensation cases

I understand that I have the right to:

- Request a restriction on the use and disclosure of my or my child's health record
- Request to inspect or obtain a copy of child's health record
- Request to correct or amend information in child's health record
- Request confidential communications
- Receive a paper copy of this notice

Park Pediatrics will not receive payment or other compensation from a third party in exchange for using or disclosing the *Notice of Privacy Practices*.

I do not have to sign this authorization in order to receive treatment from Park Pediatrics. I acknowledge that I have the right to refuse to sign this authorization notice. **I have read the full version of *Notice of Privacy Practices*.** When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Park Pediatrics has acted in reliance upon this authorization. My written revocation must be submitted to Park Pediatrics at: Park Pediatrics, 7610 Carroll Avenue, Suite 400, Takoma Park, MD 20912.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

For 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 _____