

Tri-Valley Pediatrics, Inc.

5565 W. Las Positas Blvd., #240, Pleasanton CA 94588

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

Conduct, plan and direct my child’s treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this practice has the right to change its Notice of Privacy Practices from time to time and that I may contact this practice at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my child’s private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Date: _____

Patient Name: _____ D.O.B. _____

Patient/Guardian Signature: _____

Relationship to Patient: _____

OFFICE USE ONLY

I attempted to obtain the parent/guardian’s signature in acknowledgement on this Notice Of Privacy Practices Acknowledgement, but was unable to do so as documented below:

_____ Date Initials Reason

Effective Date: April 14, 2003