



Patient Name: _____

Date of Birth: _____

PATIENT ACKNOWLEDGEMENT Health Insurance Portability and Accountability Act (HIPAA)

Our **Notice of Privacy Practices** provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this acknowledgement. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

If you would like to receive a copy of the Summary and complete Notice, we have one available for you by request.

If you wish for persons other than those released under normal operations as indicated in the Notice to receive confidential information that is now protected under this law, you must release them in writing. Please indicate on your patient registration form spouse, or any family or friends whom you wish to be able to receive information about you. You may of course choose not to release anyone. You may also be more specific in your restrictions for the persons you have released, just provide that request in writing. Parents or Guardians of minor children do not need to be released.

We have found that the easiest way to identify persons who are inquiring about your information is for you to assign a security password to your account. Persons who call will be asked this password instead of your social security information. Please be aware that our staff has to follow federal law on information that we release by phone and we may at any time choose not to release information of any kind by phone if we feel that the person requesting information is not authorized or we feel the information may be too sensitive to release by phone.

By signing this form, you are acknowledging that the Vital Pediatrics for Complex Kids, LLC d/b/a Patti's Place has made our Notice of Privacy Practices available to you for review and that we have offered you a personal copy.

I authorize Vital Pediatrics for Complex Kids, LLC d/b/a Patti's Place to use and disclose my protected health information (PHI). We may make your protected health information available electronically through an electronic health information exchange to other health care providers that request your information for their treatment purposes. In all cases the requesting provider must have or have had a treating relationship with you. Participation in an electronic health information exchange also lets us see other provider's information about you for our treatment purposes.

I agree to health information exchange

I do not agree to health information exchange

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at (office address or e-mail address). I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Personal Representative

Date