Virginia Pediatrics and Adolescent Medicine, PLC

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

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

I have received, read and understand Virginia Pediatrics and Adolescent Medicine, PLC *Notice of Privacy Practices* containing more complete description of the uses and disclosures of my health information. I understand that Virginia Pediatrics and Adolescent Medicine, PLC, has the right to change its *Notice of Privacy Practices* from time to time and I may contact at any time during normal business hours and obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that Virginia Pediatrics and Adolescent Medicine, PLC restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that Virginia Pediatrics and Adolescent Medicine, PLC is not required to agree to my requested restrictions, but if agreed, is bound to abide by such restrictions.

☐ I Do Not authorize Virginia Pediatrics and Adolescent Medicine, PLC to discuss my billing/medical information with any other individual.

I authorize Virginia Pediatrics and Adolescent Medicine, PLC to discuss my billing/medical information with:

☐ Parents of minor child authorized only

☐ Other: Name:_____ Relationship:_____

Patient Name:_____ Relationship to patient:_____

Signature:_____ Date:_____

I have received a copy of this acknowledgement (initial) _____

OFFICE USE ONLY

Virginia Pediatrics and Adolescent Medicine, PLC attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices, but was unable to do so as documented below:

Date: ___/___/_____ Staff Initial: _____ Reason:_____