Twickenham Pediatrics, PC

MURIEL DESIMONE, M.D., F.A.A.P.
LORIE DAWSON, M.D., F.A.A.P.
KELLI STRINGER, M.D., F.A.A.P.

PRIVACY PRACTICES (HIPAA) ACKNOWLEDGEMENT

I HAVE REVIEWED THE NOTICE OF PRIVACY PRACTICES OF TWICKENHAM PEDIATRICS, PC AND HAVE BEEN OFFERED THE OPPORTUNITY TO RECEIVE A COPY.

IF CHILD IS 16 OR OLDER, THEY MUST SIGN THIS FORM THEMSELVES – IF THEY WOULD LIKE US TO BE ABLE TO PROVIDE INFORMATION TO THEIR PARENTS, THEY MUST NAME THEM SPECIFICALLY WHERE NOTED.

Child No. 1 Name _____ DATE OF BIRTH _____

SIGNATURE (if 16 or older) _____ DATE _____

Can release information to: _____

Child No. 2 Name _____ DATE OF BIRTH _____

SIGNATURE (if 16 or older) _____ DATE _____

Can release information to: _____

Child No. 3 Name _____ DATE OF BIRTH _____

SIGNATURE (if 16 or older) _____ DATE _____

Can release information to: _____

Patient/Parent/Legal Guardian:

Name: _____ DATE OF BIRTH _____

SIGNATURE _____ DATE _____

..... FOR OFFICE USE ONLY .....

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES, BUT ACKNOWLEDGEMENT COULD NOT BE OBTAINED BECAUSE:

☐	INDIVIDUAL REFUSED TO SIGN
☐	COMMUNICATION BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGEMENT
☐	AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING ACKNOWLEDGEMENT
☐	OTHER (Please Specify)

NAME OF STAFF MEMBER _____

SIGNATURE _____ DATE _____