Notice of Privacy Acknowledgement

KENDALL PEDIATRIC PARTNERS

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your "Notice of Privacy Practices." I also understand that this practice has the right to change its "Notice of Privacy Practices" and that I may contact the practice at any time to obtain a current copy of the "Notice of Privacy Practices."

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

For office use only:

We have made the following attempt to obtain the patient's signature acknowledging receipt of "Notice of Privacy Practices":

Date: _____ Attempt: _____

Staff Name: _____