Health Care Insurance Portability and Accountability Act (HIPAA)

I have been provided with a *Notice of Privacy Practices* from the St Christopher's Pediatric Associates. I understand that I have the right to refuse to sign this acknowledgement.

Patient Name: ____ MRN: ______________________

Signature: ____ Date: ______________________

Patient Name Printed: ____

Parent Sign Here if Patient is a
Minor: ____ Date: ______________________

____________________________________ obtained from ____________________________________
Verbal Consent Patient Relation

Office Use Only

We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_______ Individual refused to sign

_______ Communication barriers prohibited obtaining the acknowledgement

_______ Emergency situation prevented us from obtaining the acknowledgement

_______ Other ____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES