



Pediatrix
"We Care For Kids"



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have received a copy of
(Name of Guardian)

PEDIATRIX 'Notice of Privacy Practices'. This Notice describes how PEDIATRIX may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

PLEASE PRINT NEATLY, AND FILL OUT THE INFORMATION LISTED BELOW.

To access your child(ren)'s health information, please list the last 4 digits of parent/guardian's social security number or 4 digit password or choice (will be your child(ren)'s password). Please share this information with anyone who has permission to access your child's information. (example: spouse, grandparents, school nurse, etc.)

LAST 4 DIGITS OF
MOTHER'S SS#

LAST 4 DIGITS OF
FATHER'S SS#

OR

4-DIGIT PASSWORD OF
CHOICE IF NO SS#

LIST OF CHILD/CHILDREN'S NAME AND DATE OF BIRTH

FULL NAME

DATE OF BIRTH

ACCT # (OFFICE USE ONLY)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Signature of Parent or Guardian)

(Date)

(Relationship to Patient)