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.)

____________	____________ OR	____________
LAST 4 DIGITS OF MOTHER'S SS#	LAST 4 DIGITS OF FATHER'S SS#	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)

IF YOU HAVE HIPAA QUESTIONS, PLEASE E-MAIL pediatrix@pediatrixmd.com

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