Choice Pediatrics

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I HAVE RECEIVED A COPY OF THE "NOTICE OF PRIVACY PRACTICES"

Name of Patient____

Signature______________________________________ Date________________

(Signature of patient representative required if the patient is a minor)

Relationship of Patient Representative to Patient______________________________

Request for Confidential Communication of Your Protected Health Information

With whom may we discuss your child's healthcare?

____________________________ Relationship to child__________________________

____________________________ Relationship to child__________________________

____________________________ Relationship to child__________________________

____________________________ Relationship to child__________________________