NOTICE OF PRIVACY PRACTICES

Under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), you have certain rights to privacy regarding your protected health information. You understand that this information can and will be used to

- Conduct, plan, and direct your child's treatment and follow-up among multiple health care providers who may be involved in your child's care both directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments, training, and physician certifications.
- Facilitate community based specialized health care available in the school system by various disciplines.

Signed acknowledgement:
I have received, read, and understand Carolina Pediatric Group's Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I also understand that I may obtain a copy of the Notice of Privacy Practice at any time at my request.

I understand that I may restrict how my child's private information is used or disclosed to carry out treatment, payment, or other health care operations. This request should be made in writing. I also understand that Carolina Pediatric Group is not required to agree with restrictions if it impedes quality care. If Carolina Pediatric Group does not agree, I will be informed, otherwise Carolina Pediatric Group is bound to abide by such restrictions.

Patient Name_____

Signature_____(date)_____

Relationship to patient_____

OFFICE USE ONLY
I attempted to obtain the parent's signature in acknowledgement of this *Notice of Privacy Practice*, but was unable to do so as documented below:
Signature and date:
Reason: