MIDDLE GEORGIA PEDIATRICS, LLC

HIPAA FORM

Acknowledgement of Receipt of Notice of Privacy Practices I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

• Obtain payment from third-party payers.

• Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand the Notice of Privacy Practices document containing a more complete description of the uses and disclosures of my health information. I understand that Middle Georgia Pediatrics, LLC has the right to change the Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below for a current copy of the Notice of Privacy Practices document.

Patient Name**:** _____ _____
Please print Relationship to patient

Signature: _____ _____
Please sign Date

You may communicate with the following individuals regarding my child's condition or course of treatment (other family members etc**.)**_____
_____

You may communicate confidential information about _____
Child's Name
Including invoices for services to the following address and/or phone numbers:

_____

_____