West Plano Pediatrics, P.A.

Receipt of Notice of Privacy Practices Written
Acknowledgement Form

I acknowledge that I have received or have been offered a copy of West Plano Pediatrics, P.A. Notice of Privacy Practices.

_____ _____

Parent/Legal Guardian Signature Date

Children's Names:

_____ _____

_____ _____

_____ _____

Please initial the following for approval of protected health information(PHI) to be communicated to you.

_____ Our practice may use or disclose your child's PHI to contact you by phone, voice mail message or by mailing appointment reminder postcards to the designated address filled out by you.

_____ Our practice may use or disclose your child's PHI to contact you by phone or voice mail message to reference clinical care including laboratory results of a non-urgent nature or routine. Our practice may use or disclose your PHI for other services benefiting you such as, but not limited to, immunization records may be faxed, at your request, verbal or written to other facilities or entities designated by you. For example, you may request by phone that your child's immunization record be faxed to the school nurse, daycare or other facility.

****

Sign below only if you are declining your Notice of Privacy Practices

I acknowledge that I have **declined** to receive or review the Notice of Privacy Practices offered by West Plano Pediatrics, P.A. I also understand that I do not have to sign this acknowledgement in order for my children to receive treatment by West Plano Pediatrics, P.A.

_____ _____

Parent/Legal Guardian Signature Date