## OUR KIDS PEDIATRICS

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**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES FORM**

Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that my child’s health information is private and confidential. I understand that Our Kids Pediatrics Staff works very hard to protect my child’s privacy and preserve the confidentiality of his/her personal health information.

I understand that Our Kids Pediatrics may use and disclose my child’s personal health information to help provide health care to the patient, to handle billing and payment, and to take care of health care operations. In general, there will be no other uses and disclosures of the information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are unusual. One example would be if a patient threatened to hurt someone.

Our Kids Pediatrics has a detailed document called the “Notice of Privacy Practices”. It contains more information about the policies and practices protecting the patient’s privacy and is attached to this acknowledgement. I understand that I have the right to read the “Notice” before signing this Acknowledgement.

Our Kids Pediatrics may update this acknowledgement and “Notice of Practices”. If I ask Our Kids Pediatrics will provide me with the most current “Notice of Privacy Practices”.

Within the Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records, restrictions on certain uses, receiving and accounting of disclosures are required by law, and requesting communication be my specified method of communications.

Our Kids Pediatrics has established procedures, which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments and authorizations, reasonable time frames for requesting information, charges for copies and non-routine needs, etc. I will assist Our Kids Pediatrics staff by following these procedures. If I choose to exercise any of my rights in the “Notice of Privacy Practices”.

My signature below indicates that I have been given a chance to review a current copy of Our Kids Pediatrics’ “Notice of Privacy Practices”

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