NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT
AND PATIENT CONSENT FOR USE AND DISCLOSURE OF PHI

PEDIATRIC CENTER FOR WELLNESS
1506 KLONDIKE RD SW STE 205 CONYERS, GA 30094

I understand that under the Health Insurance Portability and 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 the treatment directly and indirectly

-Obtain payment from a third-party payer

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

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the use and disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

With my consent, Pediatric Center For Wellness may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out daily operation such as appointment reminders, insurance items and any call pertaining to my child's clinical care including laboratory results among others.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____

Patient Name Relationship to Patient

_____

Printed Name Signature Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

_____

Date **Initials** **Reason**