ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you notification of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. A hardcopy is posted in the office, copies of the current notice are available in the office and by accessing our website at www.peacockpediatrics.com.

Please sign this form to acknowledge our office informed you of the Notice of Privacy Practices. You may refuse to sign this acknowledgement, if you wish.

Acknowledgement:

I acknowledge that I have received a copy of the Notice of Privacy Practices or been offered a copy but declined.

_____ _____

(Patient Name) *(Date of Birth)*

_____ _____

(Signature of Patient or Patient's Representative) *(Date)*

_____

(Relationship to Patient)

For Office Use Only:

I attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices from the individual noted above, but it could not be obtained because:

- ☐ An emergency prevented us from obtaining acknowledgement
- ☐ A communication barrier prevented us from obtaining acknowledgement
- ☐ The individual was unwilling to sign
- ☐ Other:

_____

_____

STAFF MEMBER SIGNATURE: _____ DATE:_____