Health Insurance Portability & Accountability Act (HIPAA)

Patient Name(s)	**Patient(s) Date of Birth**

Father's Name (or legal guardian)	**Mother's Name (or legal guardian)**

I have been informed and understand that under the **Health Insurance Portability & Accountability Act (HIPAA)**, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

a) Provide & coordinate my child's treatment among all healthcare provider and agencies who may be involved in the treatment directly or indirectly.

b) Obtain payment from third-party payers.

c) Conduct normal healthcare operations such as quality assessments, improvement activities and physicians certification.

By signing below, I acknowledge that I have been offered your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my child's 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 to obtain a current copy of the *Notice of Privacy Practices* . I further understand that I may request in writing that you restrict how my child's protected health 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.

Parent or Legal Guardian Sign & Date

Signature	**Date**

Name (printed)