RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

The Privacy Act requires that you be informed of your rights to patient privacy. In order to demonstrate that you were advised of your right to privacy of your medical records, we ask that you complete the following:

I, _____ (Legal Guardian's Name) am the responsible party for

Child's Name_____ Date of Birth_____

I am related to the child by _____ (Indicate Relationship).

Please list who **IS NOT ALLOWED** to have access to your child's financial and medical history:

_____

1. Offered (but refused to read/sign) _____ (check here**) –or--,**
2. Reviewed _____, (check here), **--or--**
3. Received (for take-home)_____ (check here),

A copy of GWINNETT PEDIATRICS & ADOLESCENT MEDICINE's Notice of Privacy Practices.

Lab Results:

May we leave your child's lab results on your voicemail? Yes___ No___

If yes, what telephone number should we leave the results on?_____

Date: _____ Signature: _____

The American Recovery and Reinvestment Act of 2009 requires that we gather additional information from you about your background. Thank you for answering the following 3 questions:

Race:

Unknown African American Asian Caucasian Filipino Hispanic
Japanese Chinese Native American Native Hawaiian
Pacific Islander Other

Ethnicity:

Hispanic Non-Hispanic Unknown/Decline

Primary Language:

English Spanish Other Unknown/Decline

How did you hear about our office?

Website Friend Ad Facebook Festival Other