RIGHT from the START PEDIATRICS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES (NOPP)

I understand that under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I have certain rights to privacy regarding my protected health information. I hereby give my consent to Right from the Start Pediatrics, SC, to use or disclose, for the purpose of carrying out treatment, payment, or health care operations all information contained in the patient record of _____. I understand that this information will be used to:

- conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly
- obtain payment from third party payers
- conduct normal healthcare operations such as quality assessments and physician certification

I have read and understood the Notice of Privacy Policies of Right from the Start Pediatrics, SC, which contains a complete description of the uses and disclosures of my health information. I understand that Right from the Start Pediatrics, SC, has the right to change its Notice of Privacy Policies from time to time and that I may contact the staff at any time to obtain a current copy of the Notice of Privacy Policies. I understand that this policy will not be copied for every patient, but should be read by every patient and will be conspicuously posted in the office of Right from the Start Pediatrics, SC, so that I may refer to it at all times.

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 that Right from the Start Pediatrics, SC, is not required to agree to my requested restrictions of disclosure.

I understand further that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

I understand that I may revoke this authorization at any time by giving written notice to Right from the Start Pediatrics, SC, of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician office. This authorization will be in effect until revoked by me.

Signature of parent / guardian or assigned representative Relationship to child

Print name Date