Notice of Privacy Practices Acknowledgement

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 that treatment directly and indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certification

I acknowledge that I have received Cornerstone Pediatrics Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Cornerstone Pediatrics has the right to change its Notices of Privacy Practices from time to time and that I may contact Cornerstone Pediatrics at any time to obtain a current copy of the Notice of Privacy Practices.

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 healthcare 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: ____

Signature: Date:

Date/Initial____________ Date/Initial___________ Date/Initial___________ Date/Initial__________
Date/Initial____________ Date/Initial__________ Date/Initial___________ Date/Initial___________

Office Use Only

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practice Acknowledgement, however was unable to do so as documented below

Date: _______________ Initials: __________ Reason: ____