JONESBORO PEDIATRICS
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Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practice. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Signature of Patient or Representative: _____ Date: _____

Print Name: _____ Relationship of Representative to Patient: _____

Child's Name: _____ _____ Date of Birth:_____

For Jonesboro Pediatrics, LLC Use Only:

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it.

Date: _____

Attempt:_____

Staff Member's Name:_____