ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

In this notice, “you” and “your” are also used to mean and pertain to “you” or to “your” child or “your children” where appropriate

The providers (physicians, nurse practitioners), nursing and administrative staff at Walpole Pediatric Associates, at the direction of the physicians, may share your health information for treatment, payment and health care operations.

I understand that my health information may be used for treatment, payment or health care operation purposes, such as:

1. Sharing my health information among providers (both inside and outside the practice), on a need to know basis, to give me treatment;
2. Using my health information for billing purposes, including giving referrals to specialists, when necessary and appropriate;
3. Sharing my health information with health insurance companies, government agencies, or other payers that request information related to benefits determination, claims filed for visits or admissions, and other billing matters;
4. Using my health information for health care operations, including monitoring the quality of care, audits and surveys, and carrying out other business and administrative activities;

I understand that all reasonable efforts will be made to protect the privacy of my health information, whether maintained on paper or electronically, and regardless of how it is communicated (paper, e-mail, fax mail).

I have been given the opportunity to read the Notice of Privacy Practices that is outlined in more detail how my health care information is used and shared with others. The Notice of Privacy Practices explains (1) when I need to give further approval for the providers to use my health information or share it outside the practice and (2) when my permission is <u>not</u> needed for the providers to use my health information or share it outside the practice (e.g. required by law, public health activities, etc.)

I understand that Walpole Pediatric Associates has reserved the right to change the Notice of Privacy Practices at any time. I may obtain a current copy of the Notice of Privacy Practice by contacting the Privacy Officer or from the Practice’s website.

My signature below constitutes my acknowledgment that I have been provided a copy of the Notice of Privacy Practices.

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Signature of patient (if over the age of 18) or parent/guardian Date

Print Name: _____