

HIPPA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that Knoxville Pediatric Associates, P.C. may share my health information for treatment, billing, and health care operations. I have been given a copy of the organization's notice of privacy practices that describes how my health information is used and shared. I understand that Knoxville Pediatric Associates P.C. has the right to change this notice at any time. I may obtain a current copy by contacting KPA Business office or by visiting the web site at www.knoxpediatrics.com.

My signature below constitutes my acknowledgment that I have been provided with a copy of the notice of privacy practices.

Print Name of Parent or Legal Representative

Signature of Parent or Legal Representative

Today's Date

If signed by legal representative, relationship to patient: _____

Child(ren)'s Name _____ Date of Birth _____

_____ Date of Birth _____

_____ Date of Birth _____

_____ Date of Birth _____

_____ Date of Birth _____