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.

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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___________