Takoma Park Pediatrics

NOTICE OF PRIVAY PRACTICES

I understand that, under the Health Insurance Portability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and may be used or disclosed for:

(Please check all that apply)

- ❑ Medical Forms (ex: school forms, daycare forms, camp forms, etc.)
- ❑ Medical Record Release
- ❑ Return to School/Work
- ❑ Other Concerns: ____

If requested by the patient, purposes may be listed as "at the request of the individual". The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

Takoma Park Pediatrics will not receive payment or other compensation from a third party in exchange for using or disclosing the *Notice of Privacy Practices*.

I do not have to sign this authorization in order to receive treatment from Takoma Park Pediatrics. I acknowledge that I have the right to refuse to sign this authorization notice. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Takoma Park Pediatrics has acted in reliance upon this authorization. My written revocation must be submitted to Takoma Park Pediatrics at: Takoma Park Pediatrics, 7610 Carroll Avenue #400 Takoma Park, MD 20912.

Patient Name ____

Relationship to Patient ____

Signature ____

Date ____

For Office Use Only:

I attempted to obtain a signature in acknowledgement of this Notice of Privacy Practices but was unable to do so as documented below.

Date _____________ Initials ____________ Reason ____