North Park Pediatrics, LLC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Profitability & Accountability Act of 1996, (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare
  Providers who may be involved in that treatment directly and indirectly.
- Obtain payment from the third party payers.
- Conduct normal healthcare operations such as quality assessment and physician certifications.

I have received, read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the **Notice of Privacy Practices**.

North Park Pediatrics, LLC
4 C North Ave, Suite 403
Bel Air, Maryland, 21014
410-879-5170
Privacy Officer- Cathy Chamberlain

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name: _____

Parent / Responsible Party Name: _____

Signature: _____ Date: _____/_____/_____

OFFICE USE ONLY: I attempted to obtain the patient's signature in acknowledgement on this **Notice of Privacy Practices Acknowledgement,** but was unable to do so as documented below:

Date: _____ Initials:_____

Additional Remarks: _____