WIMBERLEY PEDIATRICS
& ADOLESCENT MEDICINE, PA

TIGER CLINIC
PEDIATRICS

ACKNOWLEDGEMENT FORM

I have received the Notice Of Privacy Practices and I have been provided an opportunity to review it.

Patient Name _____ DOB _____

Parent or Guardian Signature _____ Date : _____

PATIENT CONSENT FORM

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

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

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my/my child's health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. 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.

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.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relaying on this consent.

Patient Name _____ Relationship to Patient _____

Signature _____ Date _____

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