CATAWBA pediatric ASSOCIATES, PA

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

Patient Name: ________________________ Date of Birth: ______________________

A Notice of Privacy Practices (NPP) is provided to all patients. This notice of Privacy Practices identifies:

1. How medical information about you may be used or disclosed
2. Your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information
3. Your rights to complain if you believe your privacy rights have been violated, and
4. Our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the forgoing, offered/received a copy of the Notice of Privacy Practices and is the patient, the patient's parent or legal guardian.

By signing this authorization, I authorize Catawba Pediatric Associates, P.A. to use and or disclose certain protected health information about my child to or for the individuals listed below:

Name: ____ **Relationship to Patient:** ________________________
Telephone: (_________)____________________ **Email:**____
Types of Information: ❐ Appointment Reminders ❐ Results (lab test, X-Ray, etc) ❐ Financial ❐ Other: ___________
Okay to contact via: ❐ Telephone ❐ Leave a Voice Mail ❐ Patient Portal & Secure Email ❐ Other: _____________

Name: ____ **Relationship to Patient:** ________________________
Telephone: (_________)____________________ **Email:**____
Types of Information: ❐ Appointment Reminders ❐ Results (lab test, X-Ray, etc) ❐ Financial ❐ Other: ___________
Okay to contact via: ❐ Telephone ❐ Leave a Voice Mail ❐ Patient Portal & Secure Email ❐ Other: _____________

Name: ____ **Relationship to Patient:** ________________________
Telephone: (_________)____________________ **Email:**____
Types of Information: ❐ Appointment Reminders ❐ Results (lab test, X-Ray, etc) ❐ Financial ❐ Other: ___________
Okay to contact via: ❐ Telephone ❐ Leave a Voice Mail ❐ Patient Portal & Secure Email ❐ Other: _____________

☐ **None of the above** **Signature:** ____

We may need to contact you regarding your medical care, appointments, test results, referrals, or any other reason. This is to acknowledge that you authorize Catawba Pediatric Associates, P.A. to contact you and how you wish to be contacted (check all that apply):

HOME PHONE: ________________________ **Leave Voicemail** ☐ **Yes** ☐ **No**

CELL PHONE: __________________________ **Leave Voicemail** ☐ **Yes** ☐ **No**

PATIENT PORTAL & SECURE EMAIL: ____

☐ **None of the above** **Signature:** ____ **Date:** _________________