**Child's Name:** _____ **Child's Date of Birth:**_____

**Parent Name (please print)**_____

## HIPAA Privacy Regulations as of September 23, 2013

Patient privacy has always been a top priority at West Atlanta Pediatrics. All of our staff is dedicated to protecting our patients' privacy. The new HIPPA privacy regulations provide medical practices and patients with an additional means to help guarantee that patient privacy is a top priority for all providers – physicians, hospitals and pharmacies- throughout the United States.

The new rules are beneficial for patients because they strengthen and set national standards for the privacy of your information. Specifically, the rules give patients more control over who can see their private medical information.

As an organization dedicated to safeguarding patients' medical records, we want patients to fully understand their medical privacy rights and know how their medical information is used. However, our number one job is to care for our patients. The final HIPPA privacy rule finds a balance. It protects patient information, but allows all essential activities to go on, which benefits all of us.

The Notice of Privacy Practices outlines specific details regarding HIPAA and your protected health information. In accordance with the federal HIPAA guidelines we ask that you sign a receipt of acknowledgement for the Notice of Privacy Practices. After reviewing the Notice of Privacy Practices, please let us know if you have any questions regarding HIPAA that we can answer for you.

ACKNOWLEDGEMENT OF RECEIPT FOR THE NOTICE OF PRIVACY PRACTICES

As a pediatric practice, we recognize that it is often necessary for people other than parents to bring children in for visits and call for phone advice. However, with the new privacy regulations, it is now necessary for us to have in writing who is able to seek care for your child, and who we are able to release information to over the telephone.

You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

**If, at any time, someone other than those who you designate below brings your child in for treatment, we will need to have written permission from you. Feel free to list a few or as many as you would like.**

_____ _____

_____ _____

**By signing below you:**

Give West Atlanta Pediatrics permission to transmit your child's medical information electronically. Electronic transmissions include insurance claims, vaccine information, prescriptions and other medical information authorized by you.

Acknowledge that you have been notified that West Atlanta Pediatrics no longer accepts Medicaid, Peachcare, Wellcare, Amerigroup or Peachstate for new patients. If you child was new to our practice after June 1, 2008 and obtains one of these insurances we will no longer be able to treat your child.

Acknowledge that you have been given a copy of West Atlanta Pediatrics office policies.

**Parent Signature** _____ **Date** _____

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**For patients 18 years and over:** Parents no longer have access to your medical information per HIPAA law. Please list anyone who is able to access your medical information and who we are able to release information to over the telephone.

_____ _____

**PATIENT SIGNATURE**_____ **Date**_____