Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name_____ Birth Date_____

Address_____

Facility name - Bloomington Pediatrics

I have been given a copy of a Bloomington Pediatrics' Notice of Privacy Practices which describes how my health information is used and shared. I understand that Bloomington Pediatrics has the right to change this Notice at any time. I may obtain a current copy by contacting the Facility Privacy Official or by visiting the web site at bloomingtonpediatrics.com

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_____ Date_____

Signature of Patient or Guardian

_____

Print Name

_____

Guardian's Title or Relationship to the Patient

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For facility use only: Complete this section if you are unable to obtain a signature.

1. If the patient or guardian is unable or unwilling to sign this Acknowledgement, or the Acknowledgement is not signed of any other reason state the reason:

_____

2. Describe the steps taken to obtain the patient's signature on the Acknowledgement:

_____

Completed by:

_____ Date_____

Signature of Facility Representative

_____

Print Name