DAYSTAR KIDS

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Child's Name: _____ DOB: _____
First Last MM/DD/YYYY

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

- Conduct, plan, and direct my child's treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal health care operations such as quality assessments and audits

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my child's 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 Private Practices.

I understand that I may request, in writing, that you restrict how my child's private information is used or disclosed to carry out treatment, payment or health care operations.

_____

Parent/Guardian Signature **Date** MM/DD/YYYY

_____

Print Name First Last **Relationship to Child**