ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Anshu Dalela, MD

Name of Patient _____ Date of Birth _____

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

I am the parent or legal representative of the above-named minor child. I have received a copy of White Cloud Pediatrics Notice of Privacy Practices, and understand that I may view or download such Notice of Privacy Practices on White Cloud Pediatrics website at www.whitecloudpediatrics.com.

I understand that White Cloud Pediatrics has the right to change their privacy practices and that I may obtain revised notices at the clinic or on the website.

Guarantor / Responsible Party's Signature: _____ Date: _____

Guarantor / Responsible Party's Name: _____

For office use only:

_____ I certify that I provided or offered to provide a paper copy of White Cloud Pediatrics Notice of Privacy Practices to the above-named individual during a clinic visit on _____. I asked such an individual to acknowledge receipt thereof by signing this form, but he or she refused.

_____ I certify that, upon request of the above-named individual, I emailed an electronic copy of White Cloud Pediatrics Notice of Privacy Practices to him or her on _____. I asked such individual to acknowledge receipt thereof either by return email or by signing this form at a subsequent clinic visit, but he or she refused.

Employee Signature _____ Date _____

Printed Name _____ Title _____