Summit Pediatrics, P.C.

6939 Williams Road, Niagara Falls, NY 14304
5320 Military Road, st 102 Lewiston, NY 14092
909 Pine Ave, Niagara Falls, NY 14301

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

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

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand you *Notice of Privacy Practices* containing a more complete description of the uses and disclosures o my 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 above to obtain a current copy of the *Notice of Private Practices*.

Patients Names_____
Add names of all children
_____

Relationship to Patients _____

Signature _____

Date _____

_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date_____Comment_____

_____

_____

_____Signature_____

Summit Pediatrics, P.C.
Patient Consent for Use and Disclosure
Of Protected Health Information

With my consent, **Summit Pediatrics, P.C.** may use and disclose protected health information (PHI) about my children to carry out treatment, payment and healthcare operations (TPO). Please refer to **Summit Pediatrics P.C.'s** Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. **Summit Pediatrics, PC**, Reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to, **Summit Pediatrics, P.C. Privacy Officer at 6937 Williams Road, Niagara Falls, NY 14304**.

I give my consent for **Summit Pediatrics, P.C.** to provide treatment and immunizations to my child/children under the guidelines of The American Academy of Pediatrics. I have the right to deny treatment and/or immunizations if I so choose.

With my consent, **Summit Pediatrics, P.C.** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my children's clinical care, including laboratory results among others.

With my consent **Summit Pediatrics, P.C.** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards as long as they are marked Personal and Confidential and patient statements.

With my consent **Summit Pediatrics, P.C**. may e-mail to me appointment reminder cards and patient statements. I have the right to request that Summit Pediatrics, P.C. restrict how it uses or discloses the PHI to carry our TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to **Summit Pediatrics, P.C.**'s use and disclosure of the PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Summit Pediatrics, P.C, may decline to provide treatment to me or my child/children.

_____ _____
Signature of Patient or Legal Guardian Date

Please list Child/Children's names above

Summit Pediatrics, P.C.