Acknowledgement of
Receipt of Notice of HIPAA Privacy Practices
of Pediatric Ophthalmology, P.C.

By signing below, I acknowledge that I have received a copy of Pediatric Ophthalmology, P.C.'s Notice of HIPAA Privacy Practices Form and that I have designated the individuals listed below, if any, to receive my or my child's medical information or to accompany my child to medical appointments. I understand that I may revoke such designation at any time with written notice to Pediatric Ophthalmology, P.C.

____
Patients Printed Name

____________________ Patient (or Parent/Guardian) Signature	____________________ Witness Signature
____________________ Printed Name and Relationship if other than the Patient	____________________ Printed Name of Witness
____________________ Date	____________________ Date

Documentation of Failure to Obtain Acknowledgement

On __________ (date), __________________ (staff member name) presented this Acknowledgement of Receipt of Notice of Privacy Practices Form to ____________________ ("the patient" or "parent of ...").
The patient/parent/guardian refused to provide a signature when requested.

The following individuals have my permission to obtain my/my child's medical information (written or verbal) without necessitating further written consent:

____________________ (name)	____________________ (relationship)
____________________ (name)	____________________ (relationship)
____________________ (name)	____________________ (relationship)

NOTE: Any organization or institution requesting health information must present a separate signed consent prior to release of those records.

The following individuals have my consent to accompany my child to an appointment at Pediatric Ophthalmology, P.C. in my absence.

____________________ (name)	____________________ (relationship)
____________________ (name)	____________________ (relationship)

(Reviewed 10/1/13)