



• 525 Pleasant Home Rd., Augusta GA 30907 • (706)860-6443 office/text • (706)925-9845 FAX •

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

PATIENT NAME: _____

DATE OF BIRTH: _____

I have received and understand this practice's Notice of Privacy Practice written in plain language. The notice provides in detail the uses and disclosures of my child's protected health information that may be made by this practice. My child's individual rights, how I may exercise these rights, and the practice's legal duties with respect to my child's information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at or controlled by this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

PARENT SIGNATURE: _____

PRINTED NAME: _____

DATE: _____



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