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## PATIENT HIPAA ACKNOWLEDGEMENT

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

I have read Eastern Pediatrics' Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my child's (children's) protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to the protected health information.

Eastern Pediatrics reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain Eastern Pediatrics' current Notice of Privacy Practices on request.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to patient (if signed by a personal representative of patient):** \_\_\_\_\_