

# RALEIGH PEDIATRIC ASSOCIATES, PA

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Chart#: \_\_\_\_\_

## ACKNOWLEDGEMENT OF HIPAA RIGHTS

I have been given a copy of Raleigh Pediatric Associates' Notice of Privacy Practices, version effective September 23, 2013. I consent to the uses and disclosures of my child's health information as outlined in the Notice.

\_\_\_\_\_ I authorize for Raleigh Pediatrics to leave medical information on voicemail at the phone numbers listed on my child's account:

Printed Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

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

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### FOR OFFICE USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

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