Acknowledgement of Receipt of Privacy Practices (HIPAA)

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

I acknowledge that a copy of Notice of Privacy Practices for Pediatric MotorWerks Occupational Therapy, LLC and Pediatric MotorWerks Physical Therapy, LLC has been made available to me. I acknowledge that Pediatric MotorWerks Occupational Therapy, LLC and Pediatric MotorWerks Physical Therapy, LLC reserves the right to modify their notice and practices, prior to implementation, in accordance with Section 164.520 of the code of Federal Regulations. Should Pediatric MotorWerks Occupational Therapy, LLC and Pediatric MotorWerks Physical Therapy, LLC change their notice, they will send a copy of a revised notice to the address I’ve provided.

\_\_Yes \_\_No Patient provides consent to release medical or other information to process billing claim.

 \_\_Yes \_\_No Patient provides consent to discuss private health information with the following individuals:

 I understand that as part of this organization’s treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity and I consent to such disclosure for these permitted uses included disclosures via fax.

I fully understand and accept/decline the terms of this consent.

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

If not signed by patient, please indicate relationship to patient (e.g., spouse)

**Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Witnessed by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Internal Use Only:

If patient or patient’s representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By (name and title): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_