Palmetto Pediatric
& Adolescent Clinic, P.A.

Acknowledgement of Privacy Practices
HIPAA Form

Please List Names and Dates of Birth For All Patients To Which This Form Will Apply.

Patient Name (First Middle, Last)	**Date Of Birth** (mm/dd/yyyy)

Primary Care Physician: _____

Preferred Method of Contact: (Please ***Choose One*** and Provide the Information for that Method)

☐ Phone #: _____ Please *Select One*: ☐ Home ☐ Cell ☐ Other

☐ Email: _____

The Health Information Portability & Accountability Act requires physician offices obtain written permission from the patient (18 years or older) or their legal representative, prior to speaking with a third party or giving information regarding our patient. This means that we cannot speak to counselors, grandparents, babysitters, etc. or mail documents unless you list the individuals or organizations that you give us permission to share information with below.

HIPAA also restricts us from speaking with the parents of patients over 18 years of age unless the patient has completed and signed an Authorization Form.

Medical providers that we referred you/your child to are excluded from this restriction to ensure continuity in their care.

SCPA participates with Carequality Clinical Data exchange, meaning other healthcare providers for which you see can access diagnoses, lab results, and immunizations from our practice. If you DO NOT want other members of your healthcare team to access this information, please select this box ☐

Please list anyone who may accompany the above listed patient(s) to appointments, receive medical information/advice, and/or schedule appointments?

Name	Relationship to Patient(s)

I understand that any person who is not a legal guardian of my child or whose name does not appear on the above list will not be given access to any medical information, will not be allowed to schedule appointments, or be allowed to accompany my child for treatment without further written permission.

I hereby acknowledge that I have been given an opportunity to review the privacy practices at Sandhills Pediatrics. I understand that I may obtain a copy of the Notice of Privacy Practices at my request.

This notice has been issued and considered effective on the date signed. We will keep this signed form on file for a minimum of six (6) years.

Name of person filling out this form (printed): _____
(Please supply the clerical staff member with a form of Identification when completing this form)

Patient or Parent/Guardian Signature: _____ **Date:** _____