# NOTICE of PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple health care providers who may be involved in the treatment directly and/or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations.

I have read and understood this Notice of Privacy Practices regarding the use and disclosure of my health information. I understand that this practice retains the right to change its Notice of Privacy Practices from time to time, and that I may contact this practice at the address listed below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out my treatment, payment or health care operations. I also understand that you are not required to agree to my required restrictions, but if you do agree, you are bound to abide by such restrictions.

Print Patient's Name: _____

**Camkids Pediatrics P.C.**
117-06 225th Street, 1Flr
Cambria Heights, NY 11411
Tel# 718-712-8511 Fax# 718-527-5624

Print Guardian's Name: _____

Guardian's Signature: _____

Date: _____

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