Royal
KIDS
Pediatric Clinic

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that ROYALKIDS CLINIC may share my health information for treatment, billing and healthcare operations. I have been provided a copy of the Notice of Privacy Practices that describes how my health information is used and shared. I understand that ROYALKIDS CLINIC has the right to change this notice at any time. I may obtain an additional copy by contacting my doctor's office.

● I acknowledge that I have received or reviewed a copy of Notice of Privacy Practices Please Initial ____

Patient/Legal Representative (Print Name):_____
Patient/Legal Representative Signature: _____
Date: _____Time:_____AM/PM
If signed by other than patient, indicate relationship to patient:_____
Witness: _____ Date:_____Time: _____AM/PM

INABILITY TO OBTAIN ACKNOWLEDGMENT

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment, and the reasons why the acknowledgment was not obtained.

Reasons why the acknowledgment was not obtained:

___Patient or Legal Representative received Notice of Privacy Practices but refused to sign Acknowledgment of Receipt

___Patient or Legal Representative unavailable to acknowledge receipt of Notice of Privacy Practices

___Other:
Patient Name: _____
Staff Signature: _____ Date: _____ Time:_____ AM/PM