



RECEIPT OF NOTICE OF PRIVACY PRACTICES

You have the right to receive a paper copy of North Central Indiana Pediatric Center of Howard Regional Health System's Notice of Privacy Practices. You may request that we give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still

I, _____, acknowledge that on ___/___/___, I received a copy of North Central Indiana Pediatric Center's Notice of Privacy Practices which describes the uses and disclosures of my protected health information that may be made by North Central Indiana Pediatric Center, and my rights and North Central Indiana Pediatric Center's legal duties with respect to my protected health information.

Print Name (Patient/Client)

Birth Date

Personal Representative Signature

Date

Print name if you are the personal representative of the patient/client:

Your relationship, for status as representative:

FOR NORTH CENTRAL INDIANA PEDIATRIC CENTER USE ONLY:

Date received: _____

Comments: _____

If not signed, indicate good faith measures to obtain signature: _____.

Staff Member Signature: _____

Date: _____

For further information please contact the Privacy Official at Howard Regional Health System at 765-453-8170.

YOU ARE ENTITLED TO A COPY OF THIS REQUEST