

HIPAA

I understand that I have the right to privacy of my protected health information as maintained by Fort Worth Pediatrics. By my signature below, I certify that I have received written notice of the protected health information privacy practices from Fort Worth Pediatrics. I have read and understand my rights to the privacy of my Protected Health Information as well as the terms and conditions of this notice.

Patient Name: _____

DOB: _____

Name and Signature of Legal Representative: _____

Relationship to Patient: _____

Date: _____