



ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED OUR HIPAA PRIVACY NOTICE

Bloom Pediatric Therapy, Inc. is required by law to keep your health information and records safe. This information may include:

- Notes from your doctor, teacher or other healthcare provider
• Medical history
• Test results
• Treatment notes
• Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information maybe used and shared.

- [] I acknowledge that I have received a copy of Bloom Pediatric Therapy, Inc. HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.
[] I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.
[] I understand Bloom Pediatric Therapy cannot disclose my health information other than as specified in the notice.
[] I understand that Bloom Pediatric Therapy reserves the right to change the notice and the practices detailed therein if it sends a copy of the revised notice to the address I have provided.

Print Name of Child

Date

Signature of Parent or Legal Representative

Relationship to Child

Please Note: It is your right to refuse to sign this Acknowledgement. HIPAA Privacy Notice Acknowledgement

OFFICE USE ONLY

I tried to obtain written Acknowledgement of our Privacy Notice by the parent/legal representative noted above. It could not be obtained for the following reason(s):

- An emergency prevented us from obtaining acknowledgement.
• The individual was unwilling to sign.
• A communication barrier prevented us from obtaining acknowledgement.
• Other: _____

Staff Member Signature

Date