

SIMI PEDIATRIC PARTNERS
2950 Sycamore Dr. Ste. # 200
Simi Valley, CA 93065

Receipt of HIPAA Notice of Privacy Practices Acknowledgement Form

I acknowledge that I have been provided the HIPAA Notice of Privacy Practices for Simi Pediatric Partners. This acknowledgement pertains to my children listed below.

Patients Name: _____

Parent/Patient Name _____ **Signature:** _____ **Date:** _____
(Please Print)

Patient Confidentiality

With whom may we share medical information? (ex.: relative, care taker)

Name: _____ Phone # _____ Relation: _____

Name: _____ Phone # _____ Relation: _____

Name: _____ Phone # _____ Relation: _____

Where and with whom may we leave medical information (lab or x-ray results, diagnosis, advice)?

Name: _____ Phone # _____ Relation: _____

Type: _____ (Ex. Voicemail, answering machine, home or cell)

Name: _____ Phone # _____ Relation: _____

Type: _____ (Ex. Voicemail, answering machine, home or cell)

Parent/Patient Signature: _____ **Date:** _____

Relation to patient: _____