PATIENT ACKNOWLEDGEMENT FORM

Children's Medical Group of Salisbury, PA's "Notice of Privacy Practices" provides information about how we may use and disclose health information about the patient.

You have the right to request restrictions on how the patient's protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

By signing this form, you acknowledge receipt of this office's Notice of Privacy Practices. You also consent to our use and disclosure of protected health information about the patient for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

_____
Child's Name

_____
Parent/Guardian Signature Date