THE PEDIATRIC CENTER, INC.

1447 Medical Park Blvd. Suite 402
Wellington, FL 33414
(561) 790-2600

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name:_____

Date of Birth:_____

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides, in detail, the uses and disclosures of my protected health information (PHI) that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Date:_____

Parent/Guardian Signature:_____

Relationship to Patient:_____