TLC Pediatrics of Frisco
Seth D. Kaplan, M.D.
Heather Hummel, M.D.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Parent/Legal Guardian

_____
Date

Children's Name:

_____ _____

_____ _____

_____ _____

Please initial the following for approval of Protected Health Information (PHI) to be communicated to you.

_____ Our practice may use of disclose your child's PHI to contact you by phone, voice mail message or by mailing appointment reminder postcard to the designated address filled out by you.

_____ Our practice may use or disclose your child's PHI to contact you by phone or voice mail message to reference clinical care including laboratory results of a non-urgent nature or routine. Our practice may use of disclose you PHI for other services benefiting you such as, but not limited to, immunization records may be faxed, at your request, verbal or written to other facilities or entities designated by you. For example, you may request by phone that your child's immunization records be faxed to the school nurse, daycare of other facility.

Sign below ONLY if you are declining your Notice of Privacy Practices

*I acknowledge that I have **declined** to receive or review the Notice of Privacy Practices offered by TLC Pediatrics of Frisco. I also understand that I do not have to sign this acknowledgement in order for my children to receive treatment by TLC Pediatrics of Frisco.*

_____ _____
Signature of Parent/Legal Guardian Date