PATIENT NAME : _____

DATE OF BIRTH : _____

PRIVACY PRACTICES (HIPAA)

By signing below, I acknowledge that I was provided with the Notice of Privacy Practices of Aquidneck Pediatrics, *LLC Kathy Pugatch, Privacy Manager (401) 847 2290.*

Please list any persons to whom your protected health information can be disclosed *(e.g., spouse, parent, etc.).*

This list should include your emergency contact person.

Name: _____Relationship _____ Phone number _____

Name: _____Relationship _____ Phone number _____

Name: _____Relationship _____ Phone number _____

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