# Washington Pediatric Associates, PC

## RECEIPT OF NOTICE OF PRIVACY PRACTICES
## WRITTEN ACKNOWLEDGEMENT FORM

_____ _____

**CHILD'S NAME** **DOB**

I _____, have received a copy of Washington Pediatric
Parent Name

Associates, PC Notice of Patient Privacy Practices.

_____ _____

Signature of Parent Date

Please list all parties that you would like to authorize to receive your child's information for HIPPA Compliance. (Family, Daycare, Schools, etc...) This list can be updated in writing by submitting an addendum form.

| Name | Facility/relationship |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Please Note: **forms will only be faxed to those listed. If individual/facility is not listed we will be unable to fax until an addendum is given. Also WPA will only fax on emergency basis. All forms must be picked up or mailed (SASE)**