

LUDLOW PEDIATRICS, INC.
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PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act (HIPAA)*, we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you have any questions or concerns regarding the use or dissemination of your personal health information please contact us.

I acknowledge that I have received a copy of **Ludlow Pediatrics, Inc. Notice of privacy Practices for Protected Health Information.**

Patient Name Printed

Date

Signature of Parent or Guardian

Relationship to Patient

I wish to be contacted in the following manner (check all that apply).

<input type="checkbox"/> Home Telephone _____ <input type="checkbox"/> O.K. to leave a message with detailed information <input type="checkbox"/> Leave message with call-back number only <input type="checkbox"/> Work Telephone _____ <input type="checkbox"/> O.K. to leave message with detailed information <input type="checkbox"/> Leave message with call-back number only <input type="checkbox"/> Written Communication <input type="checkbox"/> O.K. to mail to my home address <input type="checkbox"/> O.K. to mail to my work/ office <input type="checkbox"/> O.K. to fax to this number <input type="checkbox"/> Cell Phone _____ <input type="checkbox"/> O.K. to leave message with detailed information <input type="checkbox"/> leave message with call-back number only

<input type="checkbox"/> Other _____ _____ _____ _____ Please list all other names of people you give permission to receive and or Exchange information with: _____ _____ _____ _____ _____ _____
