

CARTERSVILLE PEDIATRIC ASSOCIATES, P.C
ACKNOWLEDGEMENT OF HIPPA RIGHTS

CHILD'S NAME _____

DATE OF BIRTH _____

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

I do hereby acknowledge that CARTERSVILLE PEDIATRIC ASSOCIATES has provided me with a notice of its privacy practices, as required by Federal Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that CARTERSVILLE PEDIATRIC ASSOCIATES will, upon request, provide me with a copy of the notice of privacy practices.

SIGNED _____

DATE _____

Office Location:

Cartersville Pediatric Associates at Cartersville
970 JF Harris Parkway, Suite 350 · Cartersville, Georgia 30120

Cartersville Pediatric Associates at Lake Pointe
3950 Cobb Parkway, NW, Suite 701 · Acworth, GA 30101