EASTMAN & VEMPATI MD, P.C.

30795 23 MILE RD SUITE 202 PHONE: (586)421-1740
CHESTERFIELD, MI 48047 FAX: (586)421-1744

Child's Full Legal Name: _____ **Date of Birth:** _____

Acknowledgement of Receipt of Notice of Privacy Information Practices

My signature on this form indicates that I have **reviewed** a Notice of Privacy Information Practices.

In the event that I have questions, I have been given the name of the Privacy Officer, whose information is listed below, who will be able to answer my questions.

Privacy Contact/Chesterfield
Dianne
30795 23 Mile Rd, Suite 202
Chesterfield Twp, MI 48047
586-421-1740

The following person(s), **other than the biological parents/ legal guardians**, who may receive my child's protected health information and/or accompany them to the office:

Name:_____ Relation:_____ Birth date_____

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Name:_____ Relation:_____ Birth date_____

As a parent or patient you have the right to:

- Inspect and copy your child's medical information that may be used to make decisions about your child's care.
- Request an amendment to your child's medical records if you feel they are incorrect or incomplete. The physician may deny my request and notify me of the reason for her/his denial.
- Request an accounting of disclosures. This is a list of disclosures for other than treatment, payment or health care operations.
- Request a restriction or limitation on the medical information used or disclosed about your child for treatment, payment or health care operations. All requests must be in writing. However, the physician has the right to deny the restriction. If she does agree to the restriction, the office will comply with your request unless the information is needed to provide you with emergency care.

_____ _____
Signature of Patient or Legal Representative Date

Office Use Only:

- Patient/legal guardian refused to sign consent, despite a good faith effort to receive acknowledgement.

_____ _____
Signature of Employee Date