Singular Pediatrics
Boston Children's
Primary Care Alliance

Acknowledgement of Receipt of Privacy Practices (18+ HIPAA)

I understand that my health information may be used for treatment, payment, or health care operations purposes, such as:

• Sharing my health information among providers (both inside and outside this practice), on a need-to-know basis, to provide me with treatment.
• Using my health information for billing purposes, including providing referrals to specialists when necessary and appropriate.
• Sharing my health information with health insurance companies, government agencies, or other payers that request information related to benefit determinations, claims filed for visits or admissions, and other billing matters.
• Using my health information for health care operations, including monitoring the quality of care, conducting audits and surveys, and carrying out other business and administrative activities.

I understand that all reasonable efforts will be made to protect the privacy of my health information, whether maintained on paper or electronically, and regardless of how it is communicated (paper, email, or fax).

I have been given the opportunity to read the Notice of Privacy Practices, which outlines in more detail how my health care information is used and shared with others. The Notice of Privacy Practices explains: (1) when I need to provide additional authorization for providers to use my health information or share it outside the practice, and (2) when my permission is not required for providers to use my health information or share it outside the practice (i.e., when required by law, for public health inquiries, etc.).

I understand that this practice reserves the right to change the Notice of Privacy Practices at any time. I may obtain a current copy of the Notice of Privacy Practices by contacting the Privacy Officer(s) or by visiting the practice's website.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices.

Patient Signature:_____ Date:_____

I _____ give permission to release information regarding my healthcare to: _____, relationship _____

Patient Signature: _____ Date: _____

This permission may be revoked at any time by me by verbal or written request.