

**Notice of Privacy Practices**  
AV Pediatrics, Allergy and Family Medicine  
Office Manager – 661-945-2221

**Effective Date:** 04/01/03

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

*We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.*

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**Acknowledgement of Receipt of Notice of Privacy Practices**

AV Pediatrics, Allergy and Family Medicine  
Office Manager – 661-945-2221

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Telephone: \_\_\_\_\_

If not signed by the patient, please indicate:

Relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient

Name of Patient: \_\_\_\_\_

DOB: \_\_\_\_\_

**Refusal to Sign**

I read the "Notice of Privacy Practices" and refuse to sign this document. I understand that AV Pediatrics, Allergy and Family Medicine may refuse to continue care for the above named patient.

I refuse to Sign: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Witness: \_\_\_\_\_