Decerina Uy MD, P.C.

649 Route 25A Suite 3
Rocky Point, New York 11778
Tel. No.(631) 509-0671; 476-7575
Fax No. (631) 509-0672

Acknowledgment of Notice of Privacy Practices & Financial Policy

Patient Information:

Patient Name:________________________________ Birth Date:__________________

Gender: M F

I understand that all reasonable efforts will be made to protect the privacy of my child's health information, whether maintained on paper of electronically, regardless of how it is communicated (paper, fax, e-mail).

I have been given the opportunity to read the NOTICE OF PRIVACY PRACTICES that outlines in more detail how my child's health care information is used and shared with others.

The NOTICE OF PRIVACY PRACTICES explains (a) when I need to give further approval, and (b) when my permission is not needed for Decerina Uy, MD, P.C. to use my child's health information or share it outside the practice. I understand that Decerina Uy, MD, P.C. has reserved 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.

My signature below constitutes my acknowledgment that I have been provided a copy of the NOTICE OF PRIVACY PRACTICES AND THE FINANCIAL POLICY.

____

Print name of Parent/Guardian

____

Signature of Parent/Guardian Date