PEDIATRIC ASSOCIATES OF DURANGO

1199 Main Avenue Suite 205

Durango, CO. 81301

970/259-PEDS(7337)

Fax 970/259-7366

Notice of Privacy Practices Acknowledgement

Patient name: _____

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to amend that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Compliance Officer.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used or disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____

Patient or legally authorized individual signature Date Time

Printed Name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative)

Notation, if any, by staff

This form will be retained in your medical record.

Last update: ___/___/___