CENTER FOR pediatric and adolescent MEDICINE, PA

CPAM CHART # _____

WE IMMUNIZE
FOLLOWING THE CDC CHILDHOOD AND ADOLESCENT IMMUNIZATION SCHEDULE

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704.799.2878 PHONE www.CPAMED.com 704.799.1627 FAX

ACKNOWLEDGEMENT OF RECEIPT OF THE PRIVACY STATEMENT

_____ _____
Name of Patient *(Please Print or Type)* Patient Date of Birth

I acknowledge I was offered and/or provided a copy of the Notice of Privacy Practices of the Center for Pediatric and Adolescent Medicine. The Notice of Privacy Practices provides information about how the Center for Pediatric and Adolescent Medicine may use and disclose protected health information on the patient listed. I was given the opportunity and encouraged to read it in full.

The Center for Pediatric and Adolescent Medicine reserves the right to revise its Notice of Privacy Practices. If the notice is modified, a copy of the revised notice may be obtained by:

- requesting a copy in person at our office
- accessing the Center for Pediatric and Adolescent Medicine web site at: www.cpamed.com
- requesting a copy be mailed

If you have any questions about the Center for Pediatric and Adolescent Medicine Notice of Privacy Practices, please contact:

Center for Pediatric and Adolescent Medicine
Attn: Privacy Administrator
136 Gateway Boulevard – Suite A
Mooresville, NC 28117-5608
704-799-2878

Required Signature

_____
Signature of Patient or Patient Representative

_____ _____
Print Name of Patient Representative and Relationship to Patient Date

INABILITY TO OBTAIN ACKNOWLEDGEMENT

A good faith effort was made to obtain an acknowledgement that the Center for Pediatric and Adolescent Medicine Notice of Privacy Practices was provided to the patient listed above or their representative. The acknowledgement was not obtained because:

- ❑ The patient was undergoing emergency treatment
- ❑ The patient or patient representative declined to sign the acknowledgement
- ❑ Other: _____

Required Signature

_____
Name of Staff Member *(Please Print or Type)*

_____ _____
Signature Date