# Acknowledgement of Receipt of HIPPA Privacy Practices

Patient Name: _______________________________________________ DOB: ____________________

Name of Parent(s) or Legal Guardian: ______________________________________________________

Dynamic Pediatric Speech Therapy, LLC is required by law to keep your/your child's health information safe.

This information may include:
* Notes from your doctor, teacher, or other healthcare provider
* Medical history
* Test Results
* Treatment notes
* Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information maybe used and shared.

______ I acknowledge that I have received a copy of Dynamic Pediatric Speech Therapy, LLC HIPPA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.

______ I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.

_____I understand Dynamic Pediatric Speech Therapy, LLC cannot disclose my health information other than as specified in the notice.

_____ I understand that Dynamic Pediatric Speech Therapy, LLC reserves the right to change the notice and the practices detailed therein if it sends a copy of the revised notice to the address I have provided.

Name of Client:__________________________________ Date: ____________________

Client Date of Birth: ___________________________

I hereby acknowledge that *Dynamic Pediatric Speech Therapy, LLC (DPST)* has provided me the opportunity to review a detailed notice of their Privacy Practices.

_____________________________________________________________ Date: _____________________
Signature of Parent or Legal Guardian