Hawthorne Pediatrics
Patient Registration Form
Notice of Privacy Practices
330 Lafayette Avenue, Hawthorne, NJ 07506

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy form time to time and that I may contract this organization at any time at the address above to obtain a current copy of the Notice of Privacy practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree them you are bound to abide by such restrictions.

Patient Name: _____ Signature: _____

Responsible Party: _____ Signature: _____

Relationship to Patient: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Staff Signature: _____ Initials: _____ Date: _____