Orchid Pediatrics, Inc.
4850 SW Scholls Ferry Rd, Suite 301
Portland, OR - 97225-1669

Orchid Pediatrics – HIPAA Privacy Acknowledgment Form

Patient Name: * _____

Date of Birth: * _____

I understand that I have certain rights regarding my protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). By signing this form:

- I acknowledge receipt of Orchid Pediatrics' Notice of Privacy Practices, which provides detailed information about how my health information may be used and disclosed.
- I understand that Orchid Pediatrics may use and disclose my health information for treatment, payment, and healthcare operations.
- I understand I have the right to request restrictions on how my health information is used or disclosed, though Orchid Pediatrics is not required to agree.
- I understand that I may revoke this acknowledgment in writing at any time, but revocation will not affect disclosures made prior to that date.

By signing below, I acknowledge that I have been offered and/or received a copy of the Notice of Privacy Practices and understand my rights under HIPAA.

PATIENT / GUARDIAN SIGNATURE * _____

Date: * _____

Printed Name: * _____

Relationship (if applicable): * _____