

# CHAPEL HILL PEDIATRIC PSYCHOLOGY, P.A.

With Adolescent, Adult and Family Services  
*Working to promote healthy development of children, youth, adults, parents and families.*

## Patient Acknowledgement Form Use & Disclosure of Protected Health Information

Chapel Hill Pediatric Psychology, P.A. has provided me with a copy of their "Notice of Privacy Practice" form. This form describes how CHPP may use and disclose protected Health information.

\_\_\_\_\_  
Patient/Parent's Initials

Our Notice of Privacy Practice states that we reserve the right to change the terms described. Should this happen, you will receive a copy by US Mail.

\_\_\_\_\_  
Patient/Parent's Initials

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

\_\_\_\_\_  
Patient/Parent's Initials

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust prior to your consent.

Client's Name \_\_\_\_\_

\_\_\_\_\_  
Signature (relationship to patient if other than self)

\_\_\_\_\_  
Date