Patient Privacy Agreement

Date: _____

To Whom It May Concern,

We at [Pediatric Practice Name] are committed to protecting the privacy of our patients. This agreement outlines how we may collect, use, and disclose your child's protected health information (PHI) in accordance with applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA).

1. Information We Collect

We may collect the following types of information:

- Personal identifiers (e.g., name, address, date of birth)
- Medical history and treatment information
- Billing and insurance details

2. Use of Information

Your child's PHI may be used for the following purposes:

- Providing medical treatment
- Billing and insurance processing
- Quality assurance and improvement

3. Disclosure of Information

We may disclose your child's PHI to:

- Other healthcare providers involved in your child's care
- Insurance companies for billing purposes
- Legal authorities when required by law

4. Your Rights

As a parent or legal guardian, you have the right to:

- Access and request copies of your child's PHI
- Request amendments to your child's PHI
- Obtain an accounting of disclosures of your child's PHI

By signing this document, you acknowledge that you have read and understood our Patient Privacy Agreement.

Signature: _____

Printed Name: _____

Relationship to Patient: _____

If you have any questions regarding this privacy agreement, please feel free to contact our office at [Office Phone Number].

Thank you,

[Pediatric Practice Name]