**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPPA)**

We are required by federal and state laws to maintain the privacy of your child's 'Protected Health Information', PHI. Your signature below indicates you have received a copy of the 'Notice of Privacy Practices and Your Rights", which describes how health care information about your child may be collected, used and disclosed for purposes of treatment or payment or for other specified purposes that are permitted and required by law. This notice also details how you may access this information.

Parent/Guardian's Signature: ______________________________ Date: ______________

Witness/Title: __________________________________________ Date: ______________

I hereby authorize any prior or present treating physician, therapist, school, hospital or other health institution, to release all medical information by any means of communication to Alaska Pediatric Therapy, LLC.

_________________________________________________________________________

Parent/Guardian Signature                                                    Date