Boston Children's Hospital
Until every child is well™

LABEL OR PRINT
NAME

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NOTICE OF PRIVACY PRACTICES SIGNATURE OF RECEIPT Page 1 of 1

Firma de acuse de recibo del Anuncio de practicas de privacidad

Please complete and sign this form to indicate that you have received a copy of the Boston Children's Hospital Notice of Privacy Practices.

Por favor complete y firme este formulario para indicar que usted ha recibido una copia del Anuncio de prácticas de privacidad del Boston Children's Hospital.

Signature of Receipt by Patient/Guardian – Firma de acuse de recibo del paciente/padre o tutor

To be completed by the patient/guardian / Debe ser completado por el paciente/padre o tutor		
Patient Last Name *Apellido del paciente*	**Patient First Name** *Nombre del paciente*	**MI** *Inicial 2° nombre*
Boston Children's MR# *No. de historial médico de Boston Children's*	**Date of Birth** *Fecha de nacimiento*	
I have received a copyof the Boston Children's Hospital Notice of Privacy Practices. *He recibido una copia del Anuncio de prácticas de privacidad del Boston Children's Hospital.*		
Signature of Patient *Firma de Paciente*	**Name of Patient (please print)** *Nombre del paciente (en letras de molde)*	**Date** *Fecha*
Signature of Parent or Guardian *Firma del padre o tutor*	**Name of Parent or Guardian (please print)** *Nombre del padre o tutor (en letras de molde)*	**Date** *Fecha*
Relationship to the patient: *Relación con el paciente:*		

Children's Hospital Use Only

Signature Declined by Patient/Guardian

To be completed by Boston Children's Hospital representative	
I have offered the Boston Children's Hospital Notice of Privacy Practices to the patient/guardian and they have declined to sign it. Reason signature was not obtained:	
Boston Children's Hospital representative Name	
Boston Children's Hospital ID#	**Date**
Receipt Tracking	
I have documented the signature of receipt in the HIPAA Privacy Tracking Database available from the Boston Children's Hospital internal web page.	
Boston Children's Hospital representative Initial	

Please file this form in the patient's medical record.

BOSTON CHILDREN'S HOSPITAL, 300 LONGWOOD AVE., BOSTON, MA 02115

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