FRIENDS OF FAMILY HEALTH CENTER

NOTICE OF PRIVACY PRACTICES

Agreement

By signing this form, you agree that you were given a copy of the *Notice of Privacy Practices of* ***Friends of Family Health Center***. Our *Notice of Privacy Practices* explains how we may use and share your protected health information. Please read it all the way through.

Our *Notice of Privacy Practices* may change. If we make any changes, you can get a copy of the new notice by calling us at (562) 690-0400 or by going to Friends of Family Health Center at 501 S. Idaho St., Suite 100, La Habra CA, 90631.

If you have any questions about our *Notice of Privacy Practices*, please call:

Mark Varallo, D.O., (562) 690-0400.

I agree that I have been given a copy of the *Notice of Privacy Practices* of *Friends of Children Health Center*.

Name: _____

Signature: _____ Date: _____
(patient/parent/conservator/guardian)

Date of Birth: _____

IF AGREEMENT CANNOT BE SIGNED

Fill this part in only when it is not possible to get an individual to sign this form.

Describe the good faith efforts made to get the individual's agreement, and the reasons why the form was not signed:

Signature of
Provider Representative: _____ Date: _____

Revised 12/16/2014 fi