Patient Acknowledgement

of

HIPAA Privacy Practices

Patient Name: _____

Date of Birth: _____

PediaLabs will maintain a record of your service visits solely for the purpose of coordinating care with my medical provider and obtaining payment for the services rendered. I provided PediaLabs consent to act on my behalf with respect to the transmission of my information for the stated purposes. If I would like to revoke this consent at anytime I will provide PediaLabs written notice.

I understand that I am contracting PediaLabs to obtain my samples and my information for the purpose of diagnosis, treatment, and payment, when necessary. By signing this form, I am acknowledging that I have received a copy signed copy of this HIPAA consent form for my documentation and record keeping. Prior to signing, I had an opportunity to read, review, and ask questions about the intent of this form.

Signature: _____

Date: _____

Relationship to patient (if signed by representative of the patient):

_____