ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(Federal HIPAA Privacy Regulations)

By my signature below I am acknowledging that the office of **GUARDIAN PEDIATRICS** has provided me with a copy of their Notice of Privacy Practices.

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Parent or Guardian Printed Name: _____

Signature: _____

Date: _____

(A copy of this form must be kept in the patient's chart.)