



Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, _____, have received a copy of Children's Medicine's Notice of Privacy Practices.
Patient/Parent/ Guardian Printed Name

Patient/Parent /Guardian Signature

Date

Please list all patients:

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____