



ACKNOWLEDGEMENT OF FEDERAL HIPAA PRIVACY PRACTICES

I hereby acknowledge that I have been presented with a copy of the Notice of Privacy Practices from Advanced Pediatrics.

DATE: _____

PRINT NAME OF PATIENT

SIGNATURE OF PATIENT REPRESENTATIVE (parent) RELATIONSHIP

The undersigned refused or failed to acknowledge receipt of this Notice of Privacy Practices

Date: _____

PRINT NAME OF PATIENT

PRINT NAME OF PERSON REFUSING

SIGNATURE OF ADVANCED PEDIATRICS EMPLOYEE