The Center for Pediatric and Adolescent Medicine

Notice of Privacy Practices for Protected Health Information and Office Policy and Procedures

WRITTEN ACKNOWLEDGEMENT FORM

Patient Name [please print]: _________________________ DOB: ____ /____/_______

I hereby acknowledge receipt of a **Summary** of your **Notice of Privacy Practices for Protected Health Information and Office Policy and Procedures.**

Parent/Guardian: _________________________ Signature: __________________________
(print)

Relationship to Patient: ☐ Parent ☐ Legal Guardian ☐ Self ☐ Other__________________

Date: ______________________

Rev: 11/11/2022