PEDIATRIC PROFESSIONAL ASSOCIATES, P.C.

PRIVACY PRACTICES ACKNOWLEDGEMENT

Patients Name: ______________________________ D.O.B.: __________________

Parents Name: ______________________________ Record #: ________________

I have been presented with a copy of Pediatric Professional Associates "Notice of Privacy Practices".

______________________________________ ________________________

Parent Signature Date

For office use only:

If parent refuses to sign, indicate your attempt to obtain a signature below.

__________________ __________________

Date Time

Employee Name: