



# Children's Medical Center

Board Certified Pediatricians

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## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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\*You May Refuse to Sign This Acknowledgement

I, \_\_\_\_\_, have received a  
(Patient or Legal Representative.....PLEASE PRINT)

copy of this office's Notice of Privacy Practices.

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**Please Print Name of Patient (1 Child Per Sheet)**

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**Signature of Patient or Legal Representative**

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**Relationship**

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**Date**

I request the following restrictions to the use or disclosure of my health information:

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### For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify)

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**Witness Signature**

**Title**

**Date**