Pediatric Group

Physician or Practice

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Dated: April 14, 2003

I, (name of patient) ____
Acknowledge and agree that I have received a copy of (Physician or Practice) Notice of Privacy Practices.

______________________________	____________________
Patient signature	Date
______________________________	____________________
Patient Legal Representative (if applicable)	Date
______________________________	____________________
Print Name of Legal Representative	Relationship to patient

FOR CLINIC USE ONLY:

(Physician or Practice) made the following good faith efforts to obtain the above referenced individual's written acknowledgement of receipt of the Notice of Privacy Practice:

(Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.)