Acknowledgement of Receipt of Privacy Notice

I, (Patients name) _____have been presented with a copy of the Premiere Pediatrics Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

Signed: _____ Date:_____

If not signed by signed by patient, please indicate relationship to patient (eg.,spouse)

Relationship:_____

Witnessed by
(Staff):_____ Date:_____

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time):_____

By: (name and title):_____