

Acknowledgment of Receipt of Privacy Notice

Original to be maintained in Patient's permanent medical record.

Scottsdale Children's Group

I acknowledge that I have received a copy of the office's Notice of Privacy Practices and understand that this policy is also posted in the office for reference:

PATIENT: _____ **DOB:** _____

X

Patient or legally authorized individual signature

Date Signed

Printed Name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative, etc.)

You have the right to review this Notice before signing the acknowledgment authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.