Kids Health Partners

RECEIPT OF PRIVACY PRACTICES

I, _____, hereby acknowledge receipt of the physicians' Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved the right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Signature: _____ **Date**: _____

If you are not the patient, please specify your relationship to the patient:

_____