Acknowledgement of Receipt of Privacy Notice

I acknowledge that I was provided with a copy of Pediatric Associates of Lewiston, P.A.'s Notice of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and state law.

Date of Implementation 4/15/03

I acknowledge that I was provided with the Notice of Privacy Practices of Pediatric Associates of Lewiston P.A.

Patient:
DOB:

*Signature of Parent/Legal Guardian_____Date:

Print Parent/Legal Guardian Name_____

Relationship of Parent/Legal Guardian_____

Signature of Witness _____Date:

For patient's 18 years of age or older

Signature of Patient _____Date:

Patient's DOB:

If the patient refuses to sign this acknowledgement, indicate your attempt to obtain a signature below.

[ ] Patient refused to sign this acknowledgment,
Date: _____
Time: _____

Reason for not obtaining the acknowledgement: _____
Employee Name: _____