



**Kids
care**
pediatrics
ANITA KISHEN MD FAAP

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Acknowledgement of Receipt of Notice of Privacy Practices

Name: _____ Date: _____

Relationship to Patient: _____

I acknowledge that I was provided a copy of the Notice of Privacy Practices for Kids Care Pediatrics.

Patient Name (Print): _____

Name of person signing acknowledgment (Print): _____

Relationship to Patient: _____

Request a copy of the notice of privacy practices? Yes No

Signature: _____ Date: _____

For Office Use

If patient/representative requested a copy of Notice of Privacy Practices: Date copy was provided: _____

If no acknowledgement could be obtained, state the reasons why and the efforts taken to try to obtain the acknowledgement:

Name: _____ Date: _____