Patient Acknowledgement
Receipt of Privacy Notice

I, _____(**Parent or Legal Guardian Name**) hereby affirm that I have received, on behalf of the patient indicated below, a copy of the *Notice of Privacy Practices* from Chapin Pediatrics, PA. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this *Notice* from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have received a copy of the *Notice* and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider in paper format or electronic format, whether I sign this Acknowledgement or not.

PATIENT(S) NAME: _____

_____ _____

_____ _____

_____ _____

_____ _____

Signature of Patient or Personal Representative (Parent or Legal Guardian)

Print Name of Patient or Personal Representative (Parent or Legal Guardian)

_____ _____

Relationship to Patient

Today's Date

_____

For Office Use Only

Received by:	
Date Received:	Time Received:
Patient Declined: ■	
Staff Signature:	