CHILDREN'S MEDICAL GROUP, P.A.

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT NOTICE / PRIVACY POLICY

_____ _____

Patient Name Date of Birth

I, (patient / parent / legal guardian) _____,

do hereby acknowledge that I have received a copy of the Patient Notice / Privacy Policy of Children's Medical Group, P.A.

_____ _____

Patient/Parent/Legal Guardian Name (Please print) Relationship to Patient
[Patient name if 18 years or older]

X_____ _____

Signature of Patient/Parent/Legal Guardian Date
[Patient must sign if 18 years or older]