**Alamo Heights Pediatrics**

Acknowledgement of Receipt of Notice of Privacy Practices

I, the parent of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge that I have received a copy of Alamo Heights Pediatrics Notice of Privacy Practices. This notice describes how Alamo Heights Pediatrics may use and disclose my child’s protected health information, certain restrictions on the use and disclosure of my child’s protected health information, and rights I may have regarding my child’s protected health information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of parent or legal guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient