



ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Buckeye Pediatrics, LLC
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*You may refuse to sign this acknowledgement.

I, (Patient or Legal Representative - Please Print) _____,
have received a copy of this office's Notice of Privacy Practices.

Please print name of Patient (one child per sheet)

Date

Signature of Patient or Legal Representative

Relationship to Patient

I request the following restrictions to the use or disclosure of my health information:

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign.
- Communication barriers prohibited obtaining the acknowledgment.
- An emergency situation prevented us from obtaining acknowledgment.
- Other (please specify).

Witness Signature

Title

Date