TRESTLEWOOD PEDIATRICS
Keeping Your Child's Health On Track

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**** Acknowledgement of Receipt of Notice of Privacy Practices ****

Name of Children **Date of Birth**

By signing below I acknowledge that I have received a copy or was offered a copy of the Notice of Privacy Practices.

_____ _____
Signature of Patient or Personal Representative Relationship to Patient

_____
Date

Office use only:

Our practice will make a good faith effort to obtain a written acknowledgement of receipt of notice provided to the individual. If written acknowledgement is not obtained our practiced must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not signed.

Refused initial _____ Physically unable to sign _____

Other _____

Employee Signature: _____ Date: _____

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