NORTH FLORIDA PEDIATRICS, PA

Acknowledgment of Receipt of Notice of Information/Privacy Practices

I acknowledge that I have received and understand North Florida Pediatrics' Notice of Privacy Practices containing a description of the uses and disclosures of my health information. I further understand that North Florida Pediatrics may update its *Notice of Privacy Practices* at may time and that I may receive an updated copy of North Florida Pediatrics' *Notice of Privacy Practices*.

_______________________________________ _______________

Printed Patient Name DOB

_______________________________________ _______________

Patient Signature Date

If completed by patient's authorized representative, please print name and sign below.

_______________________________________ ___________________________

Printed Patient Authorized Representative Name Relationship to Patient

_______________________________________ _______________

Patient Authorized Representative Signature Date

For North Florida Pediatrics Use Only

Complete this form if unable to obtain signature of patient or patient's authorized representative.

North Florida Pediatrics made a good faith effort to obtain patient's written acknowledgment of the Notice of Information/Privacy Practices but was unable to do so for the reasons documented below:

- ☐ Patient or patient's authorized representative refused to sign
- ☐ Patient or patient's authorized representative unable to sign
- ☐ Other ____

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Printed Employee Name

_______________________________________ ___________________________

Employee Signature Date