

# Written Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and disclose PHI about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I, \_\_\_\_\_ (Please print name) have reviewed a copy of Richmond Pediatrics' Notice of Privacy Practices.

I have had an opportunity to read the Notice of Privacy Practices.

I understand that I may ask questions to Richmond Pediatrics if I do not understand any information contained in the Notice of Privacy Practices.

\_\_\_\_\_ (Please fill in other children below)  
Patient Name or Patient Signature

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature of Authorized Representative of Patient

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date