



GWINNETT PEDIATRICS & ADOLESCENT MEDICINE

**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.**

The Privacy Act requires that you be informed of your rights to patient privacy. In order to demonstrate that you were advised of your right to privacy of your medical records, we ask that you complete the following:

I, _____ (Legal Guardian's Name) am the responsible party for

Child's Name (List All)	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

. I am related to the child by _____ (Indicate Relationship).

I have been (**Check one block only**):

1. Offered (but refused to read/sign) _____ (check here) **--or--**,
2. Reviewed _____, (check here), **--or--**
3. Received (for take-home) _____ (check here),

a copy of **GWINNETT PEDIATRICS & ADOLESCENT MEDICINE's** Notice of Privacy Practices.

Lab Results:

May we leave your child's lab results on your voicemail? Yes___ No___

If Yes, what telephone number should we leave the results on? _____

Date: _____

Signature: _____