# ACKNOWLEDGEMENT OF RECEIPT OF
# NOTICE OF PRIVACY PRACTICES

## Sun City Kidz Clinic, P.A.

Your signature below acknowledges that you have received a copy of the Privacy Policies and Practices Notice from the office of Sun City Kidz Clinic, P.A. This document provides information about how we may use and disclose your protected information. We encourage you to read it in full.

Your signature also acknowledges receipt of our Payment Policy Notice as well as our General Office Policies.

| | |
|---|---|
| Signature of Patient/Patient Representative | Date |
| Name of Patient/Patient Representative (Please Print) | Relationship to Patient |

**OFFICE USE ONLY:**

We attempted to obtain written acknowledgement of patients' receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason:

□ Patient representative refused to sign

□ Emergency Situation Prevented Signature

□ Other (Please Specify) ________________________________________________________

| | |
|---|---|
| Provider Representative Signature | Date |