

**REMINDER: PLEASE BE CERTAIN THAT YOU SIGN A COPY OF THE ACKNOWLEDGEMENT AS IT APPEARS BELOW THAT WILL BE MAINTAINED IN YOUR DESIGNATED RECORD SET.**

**Acknowledgment of Review of  
Notice of Privacy Practices**

**I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.**

**Please list all children being treated by our office that this release applies to: (please print)**

**Child:** \_\_\_\_\_

**Child:** \_\_\_\_\_

**Child:** \_\_\_\_\_

**Child:** \_\_\_\_\_

**Child:** \_\_\_\_\_

**Child:** \_\_\_\_\_

**Please list all family members that may seek treatment and receive medical information for these children. (please print)**

**Family:** \_\_\_\_\_

**Family:** \_\_\_\_\_

**Family:** \_\_\_\_\_

**Family:** \_\_\_\_\_

**Current address:** \_\_\_\_\_

**Phone contact:** \_\_\_\_\_

**Insurance carrier:** \_\_\_\_\_

**Signed:** \_\_\_\_\_

**Relationship to children:** \_\_\_\_\_

**Date:** \_\_\_\_\_