

**Pediatric Surgical Associates  
Acknowledgement of Receipt of Notice of Privacy Practices**

I have been provided with a Notice of Privacy Practices that provides me a more complete description of uses and disclosures of certain health information. I understand Pediatric Surgical Associates reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy on the clinic website, and in the physician's office. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or requesting a copy in person at my appointment.

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient/Legal Representative Signature

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

The following names are of people I would like to be involved in or have access to my protected health information on a regular basis. I give permission for Pediatric Surgical Associates to share my protected health information with:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship