

# North Fulton Pediatrics

## Receipt of Notice of Privacy Practices Written Acknowledgement Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I, \_\_\_\_\_, have had the opportunity to review a copy of North Fulton Pediatrics Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Patient/Parent/Guardian Date

\_\_\_\_\_  
Relationship to patient

**FOR INTERNAL USE ONLY**

Patient/Parent/Guardian refused to sign \_\_\_\_\_  
Date Initials

I hereby grant permission to North Fulton Pediatrics to contact me and/or leave a message at either my home or workplace. These numbers are on file and can be used to confirm an appointment, to notify me that test results are available, to notify me that a form or prescription is ready for pick-up, or to conduct any other relevant business that is deemed necessary.

*Personal or detailed information will not be left on an answering machine or voice mail.*

\_\_\_\_\_  
Signature of Patient/Parent/Guardian

**FOR INTERNAL USE ONLY**

Patient/Parent/Guardian refused to sign \_\_\_\_\_  
Date Initials