

FAIRFAX PEDIATRIC ASSOCIATES, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge and agree that I have received a copy of or have been given the opportunity to review the Fairfax Pediatric Associates, P.C.'s Notice of Privacy Practices.

Child's Full Name

Date of Birth

Patient Legal Representative (if applicable)

Date

Print Name of Legal Representative

Relationship to patient

FOR CLINIC USE ONLY:

A Fairfax Pediatric Associates, P.C., physician or staff member made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:

[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.]