

**SUBURBAN PEDIATRICS, P.C.**

**NOTICE OF PRIVACY PRACTICES  
Acknowledgment of Receipt**

By signing this form, I acknowledge receipt of the Notice of Privacy Practices of Suburban Pediatrics, P.C. The Notice of Privacy Practices provides information about how the practice may use and disclose my protected health information.

The Notice of Privacy Practices is subject to change. If it is changed, a copy of the revised Notice will be posted in the office of Suburban Pediatrics, P.C. and I may request a copy at any time.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Legal Guardian

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name of Patient (if other than above)

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

**INABILITY TO OBTAIN ACKNOWLEDGMENT**

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe the good faith efforts made to obtain acknowledgement and the reasons why the acknowledgment was not obtained.

\_\_\_\_\_  
Signature of Provider Representative

\_\_\_\_\_  
Date