

REDWOOD PEDIATRIC AND ADOLESCENT MEDICINE, LLC

Acknowledgement of Receipt of the Notice of Privacy Practices

I have been given a copy of the Notice of Privacy Practices that describes how my health information is used and shared. I understand that this practice has the right to change this notice at anytime. I may obtain a current copy by contacting the Privacy Officer.

My signature below constitutes my acknowledgement that I have been provided with a copy of the Notice of Privacy Practices.

Name of patient: _____

Signature of Patient or Legal Representative

Date

If signed by the legal representative, relationship to patient: _____