ADVANCED NEIGHBORHOOD PEDIATRICS, LLC.
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Medical Record No._____

Relationship to Patient: _____

I have been given a copy of Advanced Neighborhood Pediatrics' *Notice of Privacy Practices ("Notice*"), which describes how my health information is used and shared. I understand that Advanced Neighborhood Pediatrics has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Facility Privacy Official, or by visiting the Advanced Neighborhood Pediatrics web site at www.anpediatrics.com.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name

_____
Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

For Office Use Only: Complete this section if you are unable to obtain a signature.

1. If the resident or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

   _____

2. Describe the steps taken to obtain the resident's (or personal representative's) signature on the *Acknowledgement:*

   _____

   Completed by:

   _____ _____
   Signature of Office Representative Date

   _____
   Print Name

File original in patient's Medical Record.