Harrisonburg Pediatrics

1947 Medical Avenue
Harrisonburg, VA 22801
(540) 434-3004

9982 Spotswood Trail
McGaheysville, VA 22840
(540) 437-3740

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge that Harrisonburg Pediatrics has given you a copy of its **Notice of Privacy Practices**. This notice explains how your health information will be handled.

I have received a copy of the **Notice of Privacy Practices**. I have been given an opportunity to ask questions about this notice and all my questions have been answered.

_____

Parent/Legal Guardian/Patient Please Print

_____

Parent/Legal Guardian/Patient Signature

Date Signed _____ If signed by patient, please give age _____

Provider Use Only **********

Acct # of patient _____ New Patient (name of pt.) _____

Parent, Legal Guardian or Patient was given the notice Yes No

Approval obtained by parent/legal guardian/patient (Give name) _____
to give notice and acknowledgement to _____
(Name of authorized individual)

Staff Signature _____ Date _____

If the parent/legal guardian/patient was unable to sign due to an emergency, or did not want to sign, please document that the notice was given and the reason why the parent/legal guardian/patient did not sign below.

Reason signature was not obtained _____
_____
_____

Effective Date 4/14/03