

## HIPAA Acknowledgement Notice of Privacy Practices

Printed Name of Patient: \_\_\_\_\_  
Patient Date of Birth: \_\_\_\_\_

**I acknowledge receipt of The Pediatric Orthopedic Center's Notice of Privacy Practices.**

Signature of Patient/Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

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### Office Use:

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

Reason: \_\_\_\_\_  
Signature of The Pediatric Orthopedic Center's Representative: \_\_\_\_\_  
Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_