



# RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient's Name: \_\_\_\_\_

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I, \_\_\_\_\_, have received or been offered a copy of **Smart Start Pediatrics'** *Notice of Privacy Practices*.

Parent/Guardian Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_