



**NOTICE OF PRIVACY PRACTICES:**

Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Magnolia Pediatrics. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. Our Notice of Privacy Practices is subject to change. If we change our Notice, you may obtain a copy of the revised Notice by visiting our website at [www.magnoliapediatrics.com](http://www.magnoliapediatrics.com) or on request from your health care team.

I acknowledge receipt of the Notice of Privacy Practices of Magnolia Pediatrics.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(patient/parent/conservator/guardian)

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 reasons why the acknowledgement was not obtained:

Signature of provider representative: \_\_\_\_\_ Date: \_\_\_\_\_

Reasons why the acknowledgement was not obtained:

Patient refused to sign.

Other or Comments:

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