LOSSIO PEDIATRICS, PLLC

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally received a copy of the NOTICE OF PRIVACY PRACTICES of LOSSIO PEDIATRICS, PLLC on the date indicated below.

Signature: _____ Date: _____

Patient: _____

Information about Agent (attach appropriate documentation):

Agent: _____

Title: _____

FOR OFFICE USE ONLY

❑ Patient/Representative Unable to Sign - Notice of Privacy Practices Provided

❑ Patient/Representative Refused to Sign - Notice of Privacy Practices Provided

❑ Other _____

Signature: _____ Date: _____

Print Name: _____