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: ___________________________