TLC PEDIATRICS
ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

Patient Name: _______________________________ Date of Birth: _________________________________

I acknowledge that I have been provided the TLC Pediatrics (“Practice”) Notice of Privacy Practices (“Notice”):

- It tells me how Practice will use my health information for the purposes of my treatment, payment for my treatment, and Practices health care operations.
- The Notice explains in more detail how Practice may use and share my health information for other than treatment, payment, and health care operations.
- Practice will also use and share my health information as required/permitted by law.

____	____
Signature of Patient or Personal Representative	Date
____	____
Name of Patient or Personal Representative	Address
____	____
Description of Personal Representative’s Authority	Telephone