

**Acknowledgement of Receipt of Notice of Privacy Practices**

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_

Facility name - Bloomington Pediatrics

I have been given a copy of a Bloomington Pediatrics' Notice of Privacy Practices which describes how my healthy information is used and shared. I understand that Bloomington Pediatrics has the right to change this Notice at any time. I may obtain a current copy by contacting the Facility Privacy Official or by visiting the web site at bloomingtonpediatrics.com

**My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:**

\_\_\_\_\_ Date \_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Guardian's Title or Relationship to the Patient

\*\*\*\*\*

**For facility use only: Complete this section if you are unable to obtain a signature.**

1. If the patient or guardian is unable or unwilling to sign this Acknowledgement, or the Acknowledgement is not signed of any other reason state the reason:

\_\_\_\_\_  
2. Describe the steps taken to obtain the patient's signature on the Acknowledgement:

Completed by: \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Facility Representative

\_\_\_\_\_  
Print Name