SOUTH COAST PEDIATRICS

Spanish ➡

Acknowledgement of Receipt for Notice of Privacy Practices

I hereby acknowledge that South Coast Pediatrics (SCP) has the **Notice of Privacy Practices** posted in the reception area. I understand that SCP may share my child's health information for treatment, billing and healthcare options. I have seen the Notice of Privacy Practices that describes how my health information is used and shared. I understand that SCP has the right to change/update this notice at any time and if I wish to obtain a copy I can request one from the receptionist.

_____ _____

Patient Name (Printed) Date of Birth

_____ _____

Signature of Parent, Legal Representative or Patient (over 18 years of age) Date

If not signed by the patient, please indicate relationship: _____

B-003 Rev. 3/18